AUTOMOTIVE INDUSTRIES

HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION
PLAN A

Effective January 1, 2012

1640 South Loop Road Alameda, CA 94502
(510) 836-2484
Or
PO Box 23120 Oakland, Ca 94623-0120
(800) 635-3105

atpa associated THIRD PARTY ADMINISTRATORS

AUTOMOTIVE INDUSTRIES WELFARE FUND

PLAN A
DIRECT PAY MEDICAL PLAN
PLAN DOCUMENT/SUMMARY PLAN DESCRIPTION

Effective Date: January 1, 2012

TRUSTEES' STATEMENT

TO: ALL ACTIVE PARTICIPANTS
FROM: BOARD OF TRUSTEES

We are pleased to present you with this **Plan Document/Summary Plan Description (SPD)** of the medical and other benefits available to active Participants in the ***Automotive Industries Welfare Fund*** who work under collective bargaining agreements that require **Plan A** benefits. This document is effective January 1, 2012, and replaces all other documents previously provided to you by the Trust Fund Office.

This document will help you understand the benefits provided by the ***Automotive Industries Welfare Fund***. You should review it and also share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of:

* the coverage provided;
* the procedures to follow in submitting claims; and
* your responsibilities to provide necessary information to the Plan.

As the Plan is amended from time to time, the Trust Fund will send you information explaining the changes. If subsequent notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

In order for the Fund to carry out its obligation to provide the maximum possible benefits to all Participants within the limits of its resources, the Board of Trustees (in its sole discretion) has the right to take any of the following actions, even if claims that have already accrued are affected:

- To amend and/or terminate any benefits provided by the Plan.
- To alter or postpone the method of payment of any benefit.
- To amend or rescind any provision of the Plan.
- To resolve any question as to the interpretation of the Plan. No employer or Union, nor any representative of an employer or Union, may interpret the Plan on behalf of the Trustees – nor may such persons act as an agent of the Trustees. Any representations made by such persons as to Plan benefits are not binding.

This authority may not be delegated to the Trust Fund Office and/or any individual Trustee or any of its Employees.

In addition, the Plan and the Trust Fund may be terminated by the Board of Trustees. In the event the Plan terminates, the Trustees, in their full discretion, will determine the disposition of any assets remaining after all expenses of the Trust have been paid; provided that any such distribution will be made only for the benefit of former participants and for the purposes set forth in the Plan. If another disposition is required by law, the disposition of the assets will be made in accordance with such law or laws.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them. If you have any questions, please call the Trust Fund Office.

READ THIS PLAN BOOKLET CAREFULLY AS IT CONTAINS PROVISIONS OF THE PLAN, PROCEDURES FOR FILING CLAIMS, SOURCES OF FORMS AND CLAIMS INFORMATION AND CLAIMS APPEAL PROCEDURES.

For disputes arising under those portions of the Plans insured by Kaiser Permanente or Health Net, service of legal process may be made upon Kaiser Permanente or Health Net at one of its local offices, or upon the supervisory official of the Insurance Department in the state in which you reside.

Este librito es un sumario en inges del servicio y ordenacion en la Automotive Industries Welfare Plan. Si usted tenga dificultad a entendar algo en este librito, contacto Associated Third Party Administrators a 1640 South Loop Road, Alameda, CA 94502. Horas de oficina son de las 9:00 A.M. hasta 5:00 P.M., Lunes por Viernes. Tambien puede llamar la oficina del administrador a (510) 836-2484 para asistencia.

You can access the ***Automotive Industries Welfare Plan*** website at www.aitrustfunds.org

The website contains information regarding the Welfare Plan and also allows registered participants secured access to their personal Health Plan enrollment and month-to-month eligibility. Please note, however, that if there is an inconsistency between the information on the website and actual Plan Documents and notices, the Plan Documents and notices control.

PRIVACY OF YOUR HEALTH INFORMATION

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires that the privacy of your personal health information be protected.

The Plan's notice of privacy practices, distributed to all Plan Administrators when they first become eligible, explains what information is considered "Protected Health Information." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information. If you need a new copy of the Plan's privacy notice, please contact the Trust Fund Office. You can access the ***Automotive Industries Welfare Plan*** website at www.aitrustfunds.org.

The website contains information regarding the Welfare Plan and also allows registered participants secured access to their personal Health Plan enrollment and month-to-month eligibility.

To comply with federal Medicare coordination of benefits regulations, you must promptly furnish to the Plan Administrator the Social Security number of all Plan Administrators, the Health Insurance Claim Number (HICN) and information on whether you and any of your covered Dependents are currently enrolled in Medicare or have disenrolled from Medicare. Lastly, please let the Fund know if you or any covered Dependents are on dialysis at this time.

QUICK REFERENCE CHART

When you need information, please check this document first. If you need further help, call the numbers listed in the following chart:

	Phone Number	Web Site
Direct Pay Medical Plan A Benefits Trust Fund Office Claims, Billing and Eligibility	(800) 635-3105 or (510) 836-2484	www.aitrustfunds.org
PPO Provider Network		
Anthem Blue Cross Prudent Buyer/Blue Card	(800) 810-BLUE	www.anthem.com
For providers within California		www.anthem.com
For providers in other states		
Anthem Blue Cross Inpatient Preauthorization & Utilization Review	(800) 274-7767	www.anthem.com
HMO Plans		
Kaiser Permanente Group No. 57	(800) 464-4000	www.kaiserpermanente.org
Health Net Group No. 68533	(800) 526-6694	www.healthnet.com
Prescription Drug Information (for all Direct Pay Plan A and Health Net Enrollees) Prescription Solutions Group No. AIWF	(800) – 797-9791	www.prescriptionsolutions.com
Managed Health Network for ALL Direct Pay Medical Plan A and HMO Enrollees	(800) 748-2559	www.members.mhn.com register with access code: aiwfmap
Dental Plan Options		
Scheduled Direct Pay Dental Plan	(800) 635-3105	www.aitrustfunds.org
Delta Dental Plan	(866) 499-3001	www.deltadentalins.com
Bright Now	(800) 497-6453	www.brightnow.com
Safeguard, A Met Life Company	(800) 880-1800	www.safeguard.net
United Concordia Plus	(866) 357-3304	www.unitedconcordia.com
United Healthcare Dental/Pacific Union Dental	(800) 999-3367	www.myucdental.com

	Phone Number	Web Site
Orthodontic Benefits	(800) 635-3105	www.aitrustfunds.org
Vision Benefits – Vision Service Plan	(800) 877-7195	www.vsp.com
Indemnity Plan Medical Benefits and Disability Benefits	(800) 635-3105	www.aitrustfunds.org
Burial Benefit	(800) 635-3105	www.aitrustfunds.org
Life Insurance (Dependents)	(800) 635-3105	www.aitrustfunds.org

Questions You May Have: If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Fund Office at their phone number listed above. As a courtesy to you, the Fund Office may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions into writing and fax or mail those questions to the Fund and obtain a written response.

An Overview of Your Health and Welfare Benefits

WHAT IS THE AUTOMOTIVE INDUSTRIES WELFARE FUND?

The Automotive Industries Welfare Fund (also referred to as the "Plan") was formed from a collaboration between Unions and employers in order to provide health and welfare benefits for individuals working in the automobile manufacturing, maintenance, and delivery industries.

This Summary Plan Description describes the benefits available to eligible Employees and their Dependents of participating employers who have agreements to provide benefits.

ENROLLING FOR COVERAGE

You should enroll in coverage when you are first eligible — within 60 days of the day you first begin participating in the Plan. Newly hired Employees are **REQUIRED** to enroll in the Direct Pay Medical/Prescription Drug Plan A for the first 12 months they are eligible. The option of enrolling in an HMO Plan will be available after the first 12 months.

Exception: Kaiser members who have had coverage within 90 days (after ceasing to be eligible for Health and Welfare coverage through Automotive Industries) are eligible to select Kaiser even though they are considered "new hires." In order to be eligible for Kaiser coverage under this rule, you must provide the Fund Office with a "Certificate of Creditable Coverage" from Kaiser.

Newly eligible Employees who work for employers that have negotiated dental benefits are **REQUIRED** to enroll in one of the Pre-paid Dental Plan options for the first 12 months they are eligible unless your Employer has purchased one of the Delta Buy-up Plans.

If you have worked for a Contributing Employer during the past 12 months, you will not be considered a new Employee and will have the option of selecting any carrier subject to the 12-month enrollment change provisions.

If your employer has negotiated for self-funded orthodontic benefits with your Union, orthodontic coverage is available to you and your eligible Dependents once you have been covered by the Plan for three months.

Please note that the Plan will request Birth Certificates, Marriage Certificates and any other relevant documentation at the time of initial enrollment or when additions are made.

CHANGING YOUR ELECTION

You may change your Medical or Dental Plan election at any time, but no more than once in a 12-month period. This rule applies even if you change your place of employment. However, you will be permitted to change Medical Plans if you move outside your HMO's service area, even if you were not enrolled in that HMO for 12 months. Note: You will remain in the same Medical Plan unless you contact the Trust Fund Office to make a change.

Any change in Plan will be effective on the first day of the month following the date the enrollment form is received by the Plan Administrator's Office. Please remember that your Dependents will be enrolled in the same Plan as you.

ENROLLING IN A MEDICAL HMO OR PRE-PAID DENTAL PLAN

This ***SPD*** describes the medical and prescription drug benefits offered through:

* the Direct Pay Medical Plan A; and
* two Indemnity Dental Plans—the Basic Delta Dental Plan administered by Delta Dental and a Scheduled Dental Plan administered by the Trust Fund Office.

If you are considering enrolling in a Health Maintenance Organization (HMO) or a Pre-paid Dental Plan, you may obtain each Plan's ***Evidence of Coverage*** and provider directory without charge from the Trust Fund Office. Read the information in the ***Evidence of Coverage*** carefully before choosing. You will be bound by the terms and conditions of the ***Evidence of Coverage and Disclosure Form*** issued by the HMO or Pre-paid Dental Plan that you select.

If you complete and return the **Enrollment Form** and select Kaiser or Health Net when you become eligible for those options, your coverage through the HMO will commence the first day of the month following the date the Trust Fund Office receives your **Enrollment Form**.

If you enroll in an HMO or Pre-paid Dental Plan, you will receive your ***Evidence of Coverage*** for your HMO or Pre-paid Dental Plan and an ID card for each family member. With your enrollment choice, your cards will be automatically ordered for you from your carrier. The Scheduled Dental Plan does not provide ID cards; the social security number of the participant will enable you to obtain services. Use your Medical HMO or Pre-paid Dental Plan ID card whenever you call to make an appointment, see your doctor, or go to a hospital or other facility. If you enroll in Kaiser, you will use your ID card to obtain prescriptions drugs at a Kaiser facility.

If you enroll in Direct Pay Plan A, or Health Net HMO, your prescription drug benefits are available through Prescription Solutions pharmacy under the Direct Pay Plan A. Prescription Solutions will issue ID cards that you must use when you obtain a prescription.

ACCIDENT AND SICKNESS DISABILITY BENEFITS

You may be eligible for accident and sickness disability payments on the first workday following a hospital confinement or disability due to an accident. Disability payments will begin on the fourth workday following a disability due to an illness.

BURIAL BENEFIT

Each Participant is automatically entitled to a burial benefit of $2,500 payable to your beneficiary, if you are entitled to medical coverage through the Fund.

LIFE INSURANCE

If you are covered for life insurance for your Dependents, the amount is specified in your employer's collective bargaining agreement with the Trust Fund.

If there is any conflict between the benefits described in this SPD/Plan Document and the fully insured Life Insurance, Disability or HMO documents, **the insured document will apply.**

Eligibility Rules

CLASSES OF ELIGIBLE EMPLOYEES

Contract Employee (Class 1 Employees): Active Employees working under a collective bargaining agreement between an employer and a participating Union which provides for contributions to the Automotive Industries Welfare Fund in accordance with the provisions of the Trust Agreement. Employees of a participating Union and the Administrative Office are also included.

Non-Contract Employees (Class 2): A Full-Time Employee, proprietor, or partner of an employer who is actively scheduled to work at least 32 hours each week at the employer's principal place of business, which is other than the employer's residence. An employer that has elected to cover Class 2 Employees must cover all its Class 2 Employees.

The following persons are excluded from Class 2 eligible status:

* a person covered by a collective bargaining agreement between the employer and a nonparticipating Union; or
* a person whose commencement date is delayed pursuant to a required waiting / probationary period for eligibility for Class 1 Employees with the same date of employment as you.
* each director of a corporate employer unless he is otherwise in an eligible status as a bona fide employee of the corporation performing services at least 32 hours each week that are other than the usual duties of a director;
* Employees covered by a collective bargaining agreement which does not provide for contributions to this Plan, unless specifically approved by the Board of Trustees; or
* any individual whose coverage under Class 1 terminates because he is a member of a group that elects to no longer be subject to a collective bargaining agreement between an employer and any participating Union and is no longer represented by such Union.

WHEN COVERAGE BEGINS

1. **Contract Employee** (Class 1 Employees): Coverage will start the first day of the month following the date your active employment begins. For example, if you commence active employment on September 7, your coverage will begin October 1. If you are terminated from employment in less than 11 working days after your first date of hire, you will not become eligible for benefits.

   However, if your employer qualifies for participation under this Plan after the date your employment begins, coverage will begin under the Plan on the date your employer qualifies and the required contributions are made on your behalf.

   Exception: If the collective bargaining agreement covering the terms and conditions of your employment clearly provides for a commencement date for your coverage which is later than the dates specified above, then you will become covered on the first day of the month for which your employer is required to contribute to the Plan on your behalf under that collective bargaining agreement.

Non-Contract Employees (Class 2): If you are a Class 2 Employee employed by your employer after the effective date the employer originally elects to cover all Class 2 Employees, you will become eligible and covered on the first day of the month following the date you commence your Active Employment and your employer makes the required contribution on your behalf.

However, if you are a Class 2 Employee employed by your employer prior to the effective date the employer originally elects to cover all Class 2 Employees, you will become eligible and covered on the date your employer qualifies with the contribution required by the Plan on your behalf.

Exception: Class 2 Employees of an employer may not have more favorable coverage commencement rules than do Class 1 Employees of that same employer. If a Class 1 Employee of your employer, with the same date of employment as you, has a later commencement date than the above rules indicate for you, then you will become covered on the first day of the month for which a contribution would have been required on behalf of a Full-Time Class 1 Employee.

WHO ARE YOUR ELIGIBLE DEPENDENTS

If you (the Employee) qualify for benefits, the following Dependents are covered at no charge to you:

Spouse

* your legal Spouse

Domestic Partner

* your Domestic Partner if there is a registered domestic partnership with a governmental body pursuant to state law.

Dependent Child(ren)

A Dependent Child is anyone who has one of the relationships with the Employee listed below, who are under the age of 26 (whether married or unmarried):

* **Natural children**;
* **Stepchildren**;
* **Legally adopted children** and children placed for adoption. Coverage for a child placed for adoption begins at the time of placement and will terminate whenever the legal duty to provide support ends.
* A child named as an "alternate recipient" under a **Qualified Medical Child Support Order** (QMCSO) who are less than 26 years of age (21 for life insurance). In accordance with ERISA Section 609(a) (2) (A), the Plan will provide coverage for a Dependent Child of an active Employee if required by a Qualified Medical Child Support Order, including a National Medical Support Order. A copy of the Plan's procedures for determining the qualified status of a medical child support order is available from the Trust Fund Office, free of charge, upon written request.
* A Child(ren) for whom you have been **legally appointed guardian** and who is declared by you as a Dependent for Federal Income Tax purposes and is less than 26 years of age (21 for life insurance); or
* A **Child(ren) of an eligible Domestic Partner** if the child is less than 26 years of age (21 for life insurance); or

* **Disabled child(ren)**: Eligible Dependent Children age 26 years and older, continue to be eligible for coverage if they are incapable of self-supporting employment because of a mental or physical disability that was present prior to age 26 and are declared by the Employee as their dependent for Federal Income Tax purposes. These disabled children are eligible for extended Medical, Dental, Orthodontic, Vision and/or Prescription Drug Expense Benefits coverage regardless of age. Proof of Disability will be requested from time to time while a Disabled child is covered under the Plan. Note that the Burial benefit and Life Insurance coverage is extended only to age 21.

A spouse of a Dependent Child (e.g. son-in-law/daughter-in-law) or child of a Dependent Child (e.g. Employee's grandchild) are not eligible for coverage under the Plan.

The term "Dependent" does not include a Spouse or Domestic Partner or additional Dependent Child who is in full-time military service.

Note regarding possible Tax Issues

If you enroll a Domestic Partner or the children of your Domestic Partner, you may be responsible for paying income tax on the imputed income value of the benefits provided.

In addition, where a state law definition of a Dependent does not match with the federal law definition of a Dependent, your employer must include in your gross income the fair market value of the coverage provided to the adult child. This is known as "imputed income." This will likely increase both the Employee's taxable income and tax liability.

You should consult with a tax specialist on these matters.

WHEN COVERAGE ENDS

Coverage ends for both Class 1 and Class 2 Employees on either the date the Plan terminates or the date you enter full-time military service. In addition, your coverage will end on the last day in the month for which your employer contributed on your behalf, except as follows:

1. **Contract Employee** (Class 1 Employees): When the contribution required by the Plan is made on your behalf, coverage will be continued until the earliest of:
   * the last day of the month following the month in which your Active Employment terminated; or
   * the date you become eligible and covered under any other health and welfare plan as an Employee of a Northern California employer engaged in the Automotive Industry.
2. **Non-Contract Employees (Class 2): Coverage will be continued until the earliest of:**
   * the end of the month in which your Full-Time employment ceased; or
   * the date you become eligible and covered under any other health and welfare plan covering Employees of any Northern California employer engaged in the Automotive Industry.
3. **Dependents: Coverage for Dependents terminates on the earlier of:**
   * the last day of the month in which they are no longer qualified for coverage, except in the case of a divorce, in which coverage terminates for the Spouse on the date of the final divorce decree, or
   * the same date that your coverage terminates.

When your coverage terminates, you and your eligible Dependents may be eligible to temporarily extend your coverage under COBRA. If you are retiring, you should check with the Trust Fund

Office as you MAY be eligible to enroll in the retiree coverage under the CMTA-IAM Joint Retiree Health & Welfare Trust.

RETROACTIVE CANCELLATION OF COVERAGE

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

If your coverage is terminated for any of the above reasons, it may be terminated retroactively to the date that you or your covered Dependent performed or permitted the acts described above.

If your coverage is terminated as contributions are not paid on time, the termination will be subject to the specific eligibility rules outlined above.

EXTENSION OF COVERAGE/SELF-PAY PROVISIONS

Disability

1. **Contract Employee** (Class 1 Employees): If a Class 1 Employee becomes disabled, his employer must make the required contributions for the three months following other contributions required on his behalf. A Class 1 Employee is entitled to such contributions on his behalf for no more than one three-month period for each disability incurred. Thereafter, the Class 1 Employee may extend his coverage only in accordance with COBRA.
2. **Non-Contract Employees** (Class 2): If a Class 2 Employee becomes disabled, he can have three months of disability coverage if his employer makes the required contributions on his behalf. A Class 2 Employee is entitled to only three months of disability coverage within the twelve month period beginning with the first month of such disability coverage. Thereafter, or if his employer does not make the required contributions, a Class 2 Employee can extend his coverage only in accordance with COBRA.

Important Note: A Class 1 or Class 2 Employee who has previously received an extension of eligibility as a result of a disability is not eligible for an additional extension of eligibility for disability unless:

* the disability is due to a cause or causes entirely unrelated to a previous disability resulting in an extension of eligibility, or any of its causes, as determined in the sole discretion of the Board of Trustees; and
* either the Employee has returned to active employment and has been an active Employee eligible for benefits under the Plan for at least three (3) months or the disability involves an inpatient hospital stay of at least two (2) days.

Leave of Absence

This provision is only applicable to Class 1 Employees who work under a collective bargaining agreement that provides for these benefits. No Class 2 Employees are eligible for benefits during a leave of absence except under the COBRA provisions of the Plan.

In the event a leave of absence is granted by the employer to a Class 1 Employee, the employer may continue to make the required contributions on his behalf during such a leave for a period not to exceed six (6) consecutive calendar months following the last month of coverage otherwise paid for by the employer.

Severance or Vacation After Termination

This provision is only applicable to Class 2 Employees. Class 1 Employees are not eligible for benefits after termination of employment except under the COBRA provisions of the Plan.

Class 2 Employees receiving Full-Time severance or vacation pay after their termination of employment may continue to be considered in Full-Time employment for a period of up to three consecutive months if the employer makes the required contribution on their behalf.

Delinquent employers

Contract Employee (Class 1 Employees): Class 1 Employees who continue to work for employers who are not in bankruptcy and who are delinquent in their contributions to the Plan may have their coverage extended for up to 18 months, but only if:

* they make timely self-payments at the employer rates applicable to their coverage; and
* their coverage is continuous.

The extension applies only to the benefits previously provided by the employer, except that contributions for retiree coverage may not be made. If the employer is still delinquent after this maximum 18-month self-pay period, coverage can only be continued under the COBRA rules described in Section 3.

If, after a Class 1 Employee has made self-payments, the Plan collects the delinquent contributions from the employer, the Plan will reimburse the Class 1 Employees of that employer who have made self-payments.

Non-Contract Employees (Class 2): Class 2 Employees who are not sole proprietors, partners or shareholders owning 5 percent or more of the shares of an employer who continue to work for an Employer who is delinquent may also self-pay for up to 18 months, but only if:

* they make timely payments at the employer rates applicable to such coverage;
* their coverage is continuous; and
* their employer is contractually bound to make contributions to the Plan on behalf of Class 2 Employees.

The extension applies only to the benefits previously provided by the employer, except that contributions for retiree and disability coverage may not be made.

Employees who are sole proprietors, partners and 5 percent shareholders may not self-pay and no coverage will be provided for them if employer contributions for all covered Employees (both Class 1 and Class 2) are not received on their behalf.

Self-Payments During Bargaining Unit Work Stoppages

Contract Employee (Class 1 Employees): Class 1 Employees whose employment ceases as a result of a bargaining unit work stoppage may self-pay as described under "Delinquent employers" above.

Non-Contract Employees (Class 2): All Class 2 Employees of an employer, whose Class 1 Employees cease employment as a result of a bargaining unit work stoppage, may self-pay for up to three months, but only if:

* timely payments are made at the employer or self-payment rates applicable to such coverage
* their coverage is continuous;
* their employer was contractually bound to make contributions to the Plan on behalf of Class 2 Employees at the time of the work stoppage; and
* no withdrawal of recognition of the Class 1 bargaining representative has occurred.

The extension applies only to the benefits previously provided by the employer, except contributions for retiree and disability coverage may not be made.

In lieu of the above-described self-payments, the employer may make contributions on behalf of all Class 2 Employees.

CONTINUED COVERAGE WHILE IN UNIFORMED SERVICE

If an Employee (and eligible Dependents) was eligible for benefits as of the date of entry into service in the Uniformed Services of the United States, and the Employee's absence from work was due to a uniformed services leave, the Employee and eligible Dependents may elect to continue coverage under USERRA by making the contributions required by the Plan for a period not to exceed the lesser of:

* 24 months beginning on the day that the uniformed service leave commences; or
* a period ending on the day after the Employee fails to return to employment within the time allowed by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

If an Employee is also eligible for COBRA, the COBRA continuation shall run concurrently with the period of USERRA coverage.

Reinstatement Following Military Service

If an Employee was eligible for benefits as of the date of entry into service in the uniformed services of the United States, and upon completion of the period of service he notifies his employer of his intent to return to employment as specified in the Uniformed Services Employment and Reemployment Rights Act of 1994, eligibility shall be reinstated. An Employee who is re-employed with a contributing employer in accord with the provisions of the Act shall be entitled to coverage under the Plan and all rights and benefits under the Plan that the Employee would have attained if the Employee had remained continuously employed with a contributing employer. In no event shall benefits be provided for illnesses or injuries determined by the Department of Veterans Affairs to have been incurred in or aggravated during performances of services in the Uniformed Services.

MEDICAL PLAN OPTIONS

Depending on where you live and how long you have been eligible, you may have a choice between receiving your medical benefits from the Indemnity Medical Plan A described in this booklet or from an HMO. You should enroll for medical benefits when you first become eligible. Your Dependents must all be enrolled in the same Plan.

You may change your election once every 12 months (unless you move outside an HMO service area). If you do not change your election, your benefits will continue under the Plan you first elected. There is no specific open enrollment period. Any change in coverage will be effective on the first day of the month following the date an updated **Plan A Enrollment and Change Form** is received by the Trust Fund Office.

Your Options

New Employees must enroll in the Direct Pay Medical Plan A option for the first 12 months after they become eligible. After the initial 12 months, Employees who live in California have the option to dis-enroll from Direct Pay Medical Plan A and enroll in either the Kaiser Permanente or the Health Net HMO. These HMO Plans are not available outside of California. Please note that there is a monthly surcharge for Employees electing the Health Net HMO.

Exception: A new Employee who lived in California may enroll in Kaiser rather than the Direct Pay Medical Plan if prior to enrolling in the Plan:

- The last Health and Welfare coverage they had was Kaiser;
- They were covered by Kaiser in the preceding 12 months; and
- They were covered under that Kaiser Plan for at least 12 months.

Contact the Trust Fund Office for enrollment forms.

Important Note to HMO Enrollees

If you are enrolled in an HMO, you must refer to the ***Evidence of Coverage*** document provided by the HMO for complete information about your network of providers, details of your benefits, the terms and conditions of coverage, procedures to follow in the event that your claim is denied and all other details regarding your medical and prescription drug benefits.

HOW THE DIRECT PAY MEDICAL PLAN A WORKS

(These benefits do not apply to HMO Plan Participants)

This is a ***Comprehensive Indemnity Medical Plan*** under which you and the Plan share the cost of ***Allowable Expenses.*** Each calendar year each participant must pay the first $200 of Allowable Expenses, which is known as the ***Deductible.*** Additional Allowable Expenses are shared between the Plan and you. Your percentage share is known as your ***Coinsurance***, and is lower when you use doctors, hospitals and other healthcare provides who are contracted with Anthem Blue Cross, known as PPO providers.

The Calendar Year Deductible

Before the Plan begins to pay any benefits, you must first satisfy a calendar year deductible. The calendar year deductible is $200 per person, or $400 per family (regardless of whether expenses are incurred from a PPO provider or non-PPO provider) each calendar year.

The following expenses are not applied toward the deductible:

* Penalties for non-compliance with any required Preauthorization or Utilization Review, or
* Charges in excess of the Allowable Expense; or
* Charges not covered by the Plan.

Percentage Payable

After the deductible is satisfied, covered services will be paid at the applicable percentage shown below until the Out-of-Pocket Maximum is met.

PPO Providers	85% of contracted rate
Non-PPO Providers	65% of Plan Allowance *
Emergency and ambulance services	85% of Plan Allowance
Out-of-area (when there is no PPO Provider within 30 miles from the Participant's home or workplace)	85% of Plan Allowance

*** Please note: Services from Non-PPO Providers will never be paid at 100%.**

Out-of-Pocket Maximum – for Contract Providers Only

If you use PPO Providers, once the amount you have paid Out-of-Pocket during a calendar year reaches $4,500 (per family unit), the Plan will pay 100% of the Allowable Expenses for most PPO covered services for the rest of that calendar year. The following chart shows the Out-of-Pocket maximum for a family unit.

Your deductible(s) accumulates towards your Out-of-Pocket Maximum.

Annual Out-of-Pocket Maximum	PPO Provider	Non-PPO Provider
Per Family unit	$4,500	None

PPO Providers

The Fund has contracted with a Preferred Provider Organization (PPO) to provide a network of Hospitals, Physicians, out-patient surgical facilities, laboratories, diagnostic facilities, and other health care providers and facilities. The PPO network is provided by Anthem Blue Cross Prudent Buyer/Blue Card. There are important advantages in using PPO Providers:

* PPO Providers have agreed to negotiated rates, which will reduce your out-of-pocket expenses.
* The Plan pays a higher percentage of charges for PPO Providers than for Non-PPO Providers.
* Except as noted below, charges of a Non-PPO Hospital or Non-PPO Outpatient Surgical Center or other Non-PPO facilities or other providers will not be applied to the $4,500 Out-of-Pocket Maximum. ***There is no limit to the patient's out-of-pocket responsibility for care in a Non-PPO Hospital, other facility or provider***.
* PPO Providers have agreed to accept assignment of benefits for Allowable Expenses and not require payment at the time of service.

PPO Providers are listed in separate directories. The listing of PPO Providers is revised periodically so it is recommended that you call or write the Trust Fund Office or go to the Anthem Blue Cross website: www.anthem.com before you receive services to determine if your doctor is a PPO Provider.

Clarification: The Plan will allow a PPO benefit for services from a Non-PPO Provider (and Allowable Expenses will accrue towards the Out-of-Pocket maximum) for the following situations:

- When a Participant does not have access to a PPO Provider within 30 miles of their home or work. However, if you receive services from a Non-PPO provider and it is later found that there is a PPO provider available that can provide the services and is located closer to you than the Non-PPO provider, services will be paid at the Non-PPO level.
- When a PPO Provider is not reasonably available; or
- Treatment for an Emergency Medical Condition is rendered at a Non-PPO facility.

Caution Regarding Use of Non-PPO Doctors and Hospitals

Except as noted above, the Plan will pay the applicable percentage of Allowable Expenses incurred by a Participant for non-PPO Providers. The percentage payable is 65% of Allowable Expenses. Non-PPO expenses do not apply towards the $4,500 Out-of-Pocket Maximum and these benefits will never be paid at 100%. ***There is no limit on the amount of out-of-pocket expense you may incur when you receive services from non-PPO Providers.***

***IMPORTANT: The following expenses are not applied toward the $4,500 Out-of-Pocket Maximum and are never paid at 100%:**

* Penalties for non-compliance with the Inpatient Preauthorization and Utilization Review Programs,
* Non-PPO expenses;
* Charges for services not covered by the Plan, or
* Charges in excess of Allowable Expenses.

<u>*Exception for Special Circumstances*</u>: Services of a Non-PPO anesthesiologist or other Non-PPO specialist service requested by an attending PPO physician will also be covered at 85% of Plan Allowance provided that services are performed at a PPO Hospital. Allowable Expenses that qualify under this Special Circumstances Exception will accrue toward the Plan's Out-of-Pocket Maximum.

Mandatory Review Programs

Except in cases of treatment for an Emergency Medical Condition and routine childbirth (see "Exceptions" at the end of this section), you must receive approval by the Review Organization before being admitted to a Hospital. If you do not receive Inpatient Preauthorization when it is required, the benefit payable for facility services will be reduced by $250. If the Review Organization does not find that the hospitalization was medically necessary, no benefits will be paid.

Failure to obtain Inpatient Preauthorization may result in a $250 benefit reduction or denial of services if services are deemed not medically necessary.

The Fund contracts with a Review Organization to administer the Mandatory Review Program. This program consists of Inpatient Preauthorization, Utilization Review, and Large Case Management. This program is administered by Anthem Blue Cross and can be contacted by calling **(800) 274-7767.**

Inpatient Preauthorization and Utilization Review

To obtain approval, you or your physician must notify the Review Organization prior to the Hospital admission by calling the toll-free number on the Quick Reference chart at the front of this booklet. This telephone number should also be listed on your membership card. The Review Organization will determine whether or not the Hospital confinement is Medically Necessary or if the procedure could be performed on an outpatient basis.

If you use a PPO Physician, your Physician will handle the Inpatient Preauthorization. If you do not use a PPO Physician, it is your responsibility to notify your Physician of the Inpatient Preauthorization program. You should confirm with the Hospital at the time of admission that Inpatient Preauthorization has been obtained.

If you do not call the Review Organization before your hospitalization, it will be reviewed when your claim is submitted. If the Review Organization finds that all or part of the confinement or care was not Medically Necessary, no Direct Pay Medical Plan A benefits will be paid.

Emergency confinements where prior approval from the Review Organization cannot be obtained are not subject to Inpatient Preauthorization. However, if you or your Dependent are admitted to a Hospital for treatment of an Emergency Medical Condition, you must notify the Review Organization as soon as possible after being admitted. The Review Organization will determine the number of days of confinement that are Medically Necessary.

After you are admitted to a Hospital, the Review Organization will determine if continued care is Medically Necessary. The length of care your Physician proposes will be reviewed, and in most cases the review confirms that intended care is appropriate. If the planned length of care appears to be too long, a physician representing the Review Organization may consult with your Physician to discuss the case further. If the two Physicians are unable to agree, you will be informed in writing. By informing you of the determination of the Review Organization, you are better able to make the decision of whether or not to remain in the Hospital. Remember, the Plan pays only for required care when it is determined to be Medically Necessary. If you are hospitalized for days which are determined to be not Medically Necessary, no Direct Pay Medical Plan A benefits will be paid.

If you do not agree with the determination of the Review Organization, you may appeal directly to the Board of Trustees following procedures described in this booklet.

Exceptions to Inpatient Preauthorization and Medical Review Programs

* You are not required to comply with this program when this Plan is the secondary payor (see the section entitled Coordination of Benefits (COB)).
* Under Federal law, ***Newborns and Mothers Health Protection Act***, benefits may not be restricted for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following normal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and insurers may not, under Federal law, require that a provider obtain authorization from the Plan or the insurers for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, compliance is required once the length of stay exceeds 48 hours (or 96 hours). Any care received after that time that is not found Medically Necessary will not be covered.

Large Case Management

In some instances, a patient's needs may be equally or better met by offering an alternative treatment to an acute care confinement. Such alternatives could include Home Health Care, Hospice Care, or care in a Skilled Nursing Facility. In those cases involving long-term disabling diseases or frequent re-admissions, the Review Organization, working with the patient's Physician, assesses whether alternative care is suitable for the patient and that health care services are carried out in a manner that ensures continuity and quality of care. Catastrophic case management is also handled by the Review Organization; for example, in cases of an organ transplant a Participant may be referred to a Center of Excellence. There is no charge to the Participant for services of a case manager.

Medical Expense Benefits Provision:

The Trustees reserve the right to waive Plan benefit limitations in order to provide for alternative treatment that would otherwise not be considered as Allowable Expense. The Board of Trustees, at their sole discretion, may authorize an amount of payment for expenses of alternate benefits which are medically necessary and which normally would require hospitalization and which represents savings for the Plan.

Direct Pay Medical Plan A Covered Services

Covered Comprehensive Medical Benefit Expenses include the following treatment, services or supplies:

Inpatient Hospital Services and Skilled Nursing

1. Hospital accommodations in a semi-private room (or intensive care unit when medically necessary) for each approved inpatient day.
2. Hospital ancillary services and supplies including:
   * General Nursing Services
   * Use of operating, diagnostic, cystoscopic, and delivery rooms
   * Surgical and anesthetic supplies, splints, casts and dressings
   * Oxygen, drugs & medical equipment used during confinement
   * Laboratory and x-ray examinations, physiotherapy and/or hydrotherapy
   * Skilled Nursing Facility - Limit of 120 days of confinement for any single disability, if approved by the Review Organization. Separate periods of inpatient confinement will be considered to be for the same disability unless the confinements were due to entirely unrelated causes, or unless:
     - For the Employee, confinements are separated by a return to work or the status of availability for work; or
     - For your Dependents, confinements are separated by at least three months.
   * Preadmission testing for outpatient diagnostic x-ray and/or laboratory testing prior to and in conjunction with a scheduled hospitalization.
   * Hospital stays in connection with childbirth for the mother or newborn child for at least 48 hours following normal delivery, or 96 hours following a cesarean section. Stays in excess of those time frames should be reviewed by the Review Organization. Routine nursery care for a newborn infant for the days in excess of 48 hours (or 96 hours as applicable) for the days that the mother's Hospital confinement is approved are also covered.
   * All covered services directly related to a hospitalization for dental services that are determined to be Medically Necessary to safeguard the health of the patient.

Outpatient Services

1. Surgery performed at an approved Outpatient Surgical Facility. You should call the Trust Fund Office or go to the Anthem Blue Cross website: www.anthembluecross.com prior to having surgery at a free-standing Surgical Center to confirm that the Facility is a contracted provider.
2. Care related to a normal pregnancy and childbirth received at a free-standing Birthing Center in lieu of a Hospital for Employee and Spouse only.
3. Outpatient radiation therapy, chemotherapy and Hemodialysis.
4. Blood transfusions, including blood processing and reasonable costs of un-replaced blood and blood products. Self-donated blood will be covered only when the blood is used, limited to the Allowed Charge that would be charged if the blood was obtained from a blood bank.
5. Allergy serum and its administration.

Organ Transplants

1. Benefits for the recipient.
2. Coverage is provided only for Covered Services directly related to transplantation of human organs or tissue (bone marrow, cornea, heart, intestine, islet tissue, kidney, liver, lung(s), pancreas, skin, or stem cells harvested from peripheral blood), including:
   a. Facility and professional services;
   b. FDA approved drugs; and
   c. Medically Necessary equipment and supplies.
3. Screening of the actual donor of organs or tissue. **NOTE**: Screening of potential donors is not covered by the Plan.
4. Organ or tissue procurement and acquisition fees, including surgery, storage, and organ or tissue transport costs directly related to a living or nonliving donor.
5. Allowed Charges incurred by a donor who is covered by this Plan, without any deductibles and coinsurance applicable to those expenses.
6. Allowed Charges incurred by a donor who is not covered by this Plan, without any deductibles and coinsurance applicable to those expenses, but only to the extent the donor is not covered by the donor's own insurance or health care plan.

Emergency Services

Hospital outpatient emergency room use (including supplies, ancillary services, drugs and medicines) when required for treatment of a true Emergency Medical Condition are covered. With respect to Non-PPO Emergency Room services, the Plan allowance is the greater of:

- the negotiated amount for in-network providers; or
- 100% of the Plan's Allowed Charge.

Important: Emergency room and related charges will not be paid for treatment that is not determined to be treatment of a true Emergency Medical Condition as defined by the Plan.

Definition of a true "Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Benefits for Surgeons

1. Benefits are provided for Medically Necessary surgical procedures.
2. Allowable Expenses include services rendered for surgery or radiotherapy by a primary operating surgeon or assisting surgeon.
3. Benefits for a second Physician or surgeon on the same case at the same time are payable when the attendance is warranted by a need for supplementary skills.
4. When regional or general anesthesia (not including local infiltration anesthesia) is provided by the primary operating or assisting Physician, the amount payable is determined by the "basic" value for anesthesia without added value for time.
5. If an incidental procedure (i.e., incidental appendectomy, lysis of adhesions, excision of previous scar, puncture of ovarian cyst) is performed through the same incision, the benefit will be based on the major procedure only.
6. Benefits for preoperative and/or postoperative professional care will be based on health industry standards.
7. Services of a Non-PPO anesthesiologist or required assistant surgeon will be covered as a PPO provider if a PPO Hospital and PPO surgeon are used and it was not reasonable for the patient to request the services of a PPO physician.

Diagnostic Radiology and Laboratory Services

1. Diagnostic x-rays, radium or radioactive isotope therapy performed by a Physician or radiologist.
2. Diagnostic laboratory examinations performed by a Physician or pathologist.

Preventive Care

In-Network Preventive Services that are required to be covered under Health Care Reform will be payable at 100%, no Deductible. Most preventive services received from a Non-PPO provider **are not covered. The only exceptions to this are:**

1. colonoscopies; and
2. sigmoidoscopies.

If a colonoscopy or sigmoidoscopy is performed at a Non-PPO facility and/or by a Non-PPO Physician, they will be reimbursed at the Non-PPO Allowance.

Please see the following Government website for a complete description of covered preventive care or call the Administrative Office with any questions you have.
http://www.healthcare.gov/law/about/provisions/services/lists.html

Preventive Care for Children

Covered Services include but are not limited to:

1. Newborn screening lab tests (typically payable as part of hospitalization at birth);
2. At least 11 office visits payable during first 30 months of age, then annual office visits are payable from age 3 years through age 18 years;
3. Hemoglobin and lead blood tests in first year of life;
4. Tuberculosis (TB) skin test in first year of life;
5. Hemoglobin blood test in second year of life; and
6. CDC recommended immunizations

Preventive Care for Men

Covered Services include but are not limited to:

1. Abdominal aortic aneurysm screening;
2. Colonoscopy, sigmoidoscopy or fecal occult blood test;
3. Four blood tests for cholesterol/lipid, blood sugar, HIV, syphilis; and
4. CDC recommended immunizations

Preventive Care for Women (including pregnant women)

Covered Services include but are not limited to:

1. Screening mammogram for breast cancer;
2. Pap smear and Chlamydia screening;
3. Osteoporosis screening x-ray;
4. Colonoscopy, sigmoidoscopy or fecal occult blood test;
5. Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV;
6. BRCA 1 and 2 lab test with family history of breast cancer; and
7. CDC recommended immunizations.

Professional Services and Supplies

1. Services rendered by a Physician, subject to the limitations and exclusions in the Plan.
2. Services rendered by Registered First Nurse Assistants, Physician Assistant or Certified Nurse Anesthetists who are acting within the scope of their license under the laws of the state or jurisdiction where the services are rendered, and who are under the direct supervision of an M.D. Reimbursement for these providers will be based on Medicare Guidelines.
3. Chiropractic services, including ancillary and related services (e.g., visit, x-rays, physical therapy) from a Physician or licensed chiropractor. Limited to twelve (12) visits per calendar year.
4. Services related to acupuncture, if performed by an M.D. or a licensed Acupuncturist, and for treatment of pain only. Limited to twelve (12) visits per calendar year.
5. When prescribed by a Physician, benefits are extended for professional services and immunizing agents for inoculation or immunization against disease. Not covered for foreign travel.

6. Services of a Registered Nurse (R.N.) or Licensed Vocational Nurse (L.V.N.) under a treatment plan supervised by a Home Health Care Agency and approved by the Review Organization and providing the services rendered are not custodial in nature and cannot be performed by a less qualified person. No benefits will be paid for the services of a Relative of the Participant or any person who resides in the Participant's home.
7. Covered ambulance services, defined as:
    - services rendered by a licensed professional ambulance for the ground transportation of a Participant to a Physician's office, or to or from a Hospital when the patient requires paramedic support;
    - services rendered by a licensed air ambulance is covered only in the event of major trauma or life-threatening medical illness when ground ambulance transport would endanger the patient's survival and only to the nearest acute Hospital or Trauma Center;
    - if Medically Necessary and specialized unique treatment is not available locally, transportation by licensed professional ambulance to the nearest location where such treatment may be obtained.
8. Outpatient rehabilitative therapy, limited to 12 visits per calendar year. However, if the therapy is provided for recovery from a stroke (i.e. cerebral vascular accident) or in connection with a related surgical procedure performed within 24 months of the therapy either on a pre-operative or post-operative basis, the Plan will cover up to but no more than 24 total visits in a calendar year.
9. Non-custodial Home Health Care services and home infusion therapy performed by a Home Health Care Agency, subject to a maximum of 150 visits per calendar year, if approved by the Review Organization.
10. FDA-approved injectable medications prescribed by a physician. If the patient is not capable of self-administering the drug, it must be provided by a licensed Home Health Care agency.
11. Hospice services performed by an approved Hospice Agency for Participants who are homebound, in the latter stages of a terminal illness, for services in lieu of hospitalization, if approved by the Review Organization.
12. Rental or purchase of prosthetic devices, medical equipment and supplies. Allowable Expenses are defined as those supplies and equipment, as approved by Medicare, which include:
    - Medically Necessary compression stockings (limit 2 per calendar year);
    - prosthetic devices and braces (including surgically implanted devices that are not otherwise excluded, corrective appliances and customized orthotics), excluding, maintenance, repairs or replacements (except when replacement is required by an anatomical or physiological change in the body of the patient); or
    - medical equipment and those supplies which are ordered by a Physician, and
        - — of no further use when medical need ends, and
        - — usable only by the Patient, and
        - — not primarily for the convenience, comfort or hygiene of the Participant, and
        - — not for environmental control, and
        - — not for exercise, and
        - — manufactured specifically for medical use, and
        - — approved as an effective and Medically Necessary treatment, as determined by the Fund, and

— not for prevention purposes.

Rental charges that exceed the reasonable purchase price for durable medical equipment are not Allowable Expenses.

13. Sterilization procedures and abortions for the Employee or Spouse only.
14. Initial infertility consultation, including laboratory tests and screening laparoscopy for the purpose of determining the diagnosis of infertility. However any subsequent treatment (any further costs) once diagnosed will not be covered.

Reconstructive Services

1. Expenses for reconstructive surgery, procedures or treatment intended to improve bodily function and/or correct a deformity resulting from disease, infection, trauma, congenital or developmental anomaly that causes a functional defect, or prior covered therapeutic procedure.
2. In the case of a Participant who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the Plan provides coverage in accordance with the ***Women's Health and Cancer Rights Act***. Allowable Expenses include:
   - reconstruction of the breast on which the mastectomy was performed;
   - surgery and reconstruction of the other breast to produce a symmetrical appearance; and
   - prostheses, mastectomy bras, and treatment of physical complications at all stages of the mastectomy, including lymphedemas.

Hearing Aid Benefit (For Eligible Dependent Children only)

This benefit is available for eligible Dependent Children only. It is not subject to the deductible and coinsurance percentages of the Plan.

A maximum of $400 is provided for a hearing aid(s) when it is prescribed by a physician. Hearing aids are limited to one of the following models: (i) in-the-ear, (ii) behind-the-ear, (iii) on-the-body, and (iv) in the eyeglass temple. The maximum payment of $400 is limited to one charge every 36 months.

The Plan will cover only the initial office visit and necessary diagnostic testing to evaluate the need of hearing aids for Dependent Children. Benefits for the initial office visit will be subject to the Plan's deductible and paid at the applicable percentage and will be excluded from the Hearing Aid Benefit limitations and provisions.

Note: Benefits for cochlear implants are provided under the Direct Pay Medical Plan A only for eligible Dependent Children enrolled in that Plan and only for congenital hearing deficits.

GENERAL DIRECT PAY MEDICAL PLAN A LIMITATIONS

The following expenses are not covered by the Plan:

1. Any injury or sickness for which a Physician does not prescribe treatment.
2. Dental services or dental supplies including hospitalization for dental services unless such hospitalization is certified as Medically Necessary by the Review Organization.
3. Eye refractions or any surgical procedure to correct refractive error.
4. Any disability covered by workers compensation or occupational disease law.
5. Any injury or sickness arising from or sustained in the course of any gainful occupation or employment. (This limitation shall not apply to covered proprietors and partners, or to self-employed Spouse.)
6. Any charges resulting from war, declared or not, armed aggression, in the commission of a crime, participation in a riot or insurrection.
7. Any supplies or services:
   - for which no charge is made;
   - for which the patient would not be legally obligated to pay in the absence of this Plan;
   - furnished or payable under any plan or law of any Government (Federal, State, Dominion or Provincial) or its political subdivision except as required by federal regulations.
8. Services or charges not related to an injury or sickness, unless specifically provided.
9. Any medical services not reasonably necessary for the care or treatment of the patient.
10. Any services or charges for the purposes of employment.
11. Hospital take-home drugs.
12. Services which are primarily cosmetic in nature, except those services listed under Reconstructive Services.
13. Charges by a physician or institution for furnishing necessary information to the Plan.
14. Medical supplies except those specifically indicated in Covered Direct Pay Medical Plan A Benefits.
15. Charges related to pregnancy of a Dependent Child.
16. Services to reverse voluntary, surgically-induced infertility.
17. Charges for the treatment of infertility and services to induce pregnancy and complications thereof, including, but not limited to services, prescription drugs, procedures or devices to achieve fertility, in vitro fertilization, low tubal transfer, artificial insemination, embryo transfer, gamete transfer, zygote transfer, surrogate parenting, donor egg/semen or other fees, cryostorage of egg/sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization procedures, except as specifically provided under the Plan.
18. Services or supplies considered by the Plan to be Experimental or not generally accepted in medical practice.
19. Charges, including speech and occupational therapy, for hyperkinetic syndromes, learning disabilities, behavioral problems, developmental delay, attention deficit hyperactivity disorder, mental retardation or autistic disease of childhood.
20. Services or treatment for mental illness or substance abuse except when provided by Managed Health Network.

21. Custodial or non-skilled care or rest cures, care in a home for the aged, nursing, convalescent, or rest home, or institution of a similar character, except as specifically provided in the Plan.
22. Screening of potential donors other than the donor actually used for transplantation of human organs or tissue.
23. Outpatient Prescription Drugs except allergy serum, and self-injectables prescribed by a physician and, if necessary, provided by a licensed Home Health Care Agency. (These items are covered under the Prescription Drug Plan).
24. Any charges for air purifiers, air conditioners, humidifiers, ramps, elevators, stair lifts, spas, pools, saunas, hot tubs and filtering systems, car hand controls, health clubs, nutritional counseling, food supplements, exercise and physical fitness programs or equipment, orthopedic shoes, wigs and supplies for comfort, hygiene or beautification.
25. Massage Therapy.
26. Emergency room charges for treatment that is not considered to be a true Emergency Medical Condition.
27. Immunizations for foreign travel.
28. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for an Emergency Medical Condition.
29. Sterilization procedures and abortions for Dependent Children.
30. Any custodial care charges.
31. Any charges related to sexual dysfunction (including but not limited to penile implants). Treatment for impotency is not covered unless it is a result of a medical condition.
32. Treatment for obesity, weight reduction, or diet control programs, including but not limited to health club memberships and physical fitness programs, and nutritional counseling and food supplements, with the exception of one per lifetime initial visit/consultation to a nutritional counselor when there is a diagnosis of medical necessity or cases of a gastric bypass that have been approved by the Review Organization as Medically Necessary.
33. Any charges for which a third party may be liable or legally responsible except as provided by the Plan's Acts of Third Parties provision.
34. Charges for services provided by a person who lives in your home or is related to you by blood or marriage.
35. Charges for gamma globulin injections as a preventive measure.
36. Charges for amniocentesis, unless the patient is 35 years or older, or if under age 35 has a previous afflicted child.
37. Charges for services associated with sex transformations and resulting complications.
38. Charges for any claim for medical treatment or services and/or supplies which is not filed within 12 months from the later of the date the expense is incurred or the date of payment under another Plan which is primary. Any exception to the foregoing will be determined solely by the Board of Trustees.
39. All services relating to pre-marital, driver's license, school entry or sports examinations.
40. Charges for care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision.
41. Charges for hypnotism, stress management, biofeedback treatment and any other goal oriented behavior modification therapy such as to quit smoking.
42. Marriage and Family Counseling.
43. Treatment for Temporomandibular Joint Syndrome (TMJ).

44. Hearing Aids and associated treatments for hearing loss, except as provided under the Hearing Aid Benefit limited to Dependent Children. Cochlear implants are covered under the Direct Pay Medical Plan A only for Dependent Children diagnosed with a congenital hearing deficit that cannot be treated with a hearing aid.
45. Services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related illness or injury.
46. Conjoint Therapy (where the Physician sees the family members without the patient being present).

MENTAL HEALTH AND ALCOHOL AND SUBSTANCE ABUSE

You may request an ***Evidence of Coverage*** booklet from the Trust Fund Office for more complete information about these benefits provided by Managed Health Network.

Member Assistance Program

These benefits are provided through Managed Health Network (MHN) and are available to ALL Direct Pay Medical Plan A and HMO Plan Enrollees.

Member Assistance Program is designed to assist with various personal problems that may be interfering with work or home life including alcohol and drug abuse, anger management, child and elder care referral, debt management referral, domestic violence, emotional distress, job stress, legal assistance referral, and relationship problems.

* Confidential counseling, up to three counseling sessions per year with no co-payment.
* Toll-free referral access, available 24 hours a day and 365 days per year.

Call (800) 748-2559

Alcohol and Substance Abuse Benefits

Alcohol and Substance Abuse coverage is available to all Employees and Dependents. Pre-authorization from MHN is required for all alcohol and substance abuse treatment. **Participants must call (800) 748-2559 for pre-authorization.**

Direct Pay Medical Plan A and Health Net Plan Participants

Benefits subject to the alcohol and substance abuse deductible, calendar year maximums, and lifetime maximum shown below. There is less out-of-pocket expense when an MHN provider is utilized.

	MHN Provider	**Non-MHN Provider**
Calendar Year Deductible	none	$250
Inpatient Coinsurance	100%	N/A
Outpatient Coinsurance	100%	50% to maximum payment of $1,000

Kaiser Permanente Plan Participants

Benefits subject to the alcohol and substance abuse deductible, coinsurance, calendar year maximums and lifetime maximum shown below. All alcohol and substance abuse benefits must be coordinated with and provided by Kaiser (except for Member Assistance Program which is provided by MHN as explained above).

Plan Benefit	Brief Description
Calendar Year Inpatient Deductible	$250
Calendar Year Maximum Inpatient Days	30
Inpatient Coinsurance	90%
Outpatient Coinsurance	90%
Outpatient Treatment Programs per Calendar Year	2

Mental Health Benefits

Direct Pay Medical Plan A and Health Net Plan Participants Only

Mental Health Non-Parity Requirements

Mental Health Benefits that are **not** subject to California Parity Requirements are subject to the calendar year limits shown below:

	MHN Provider	Non-MHN Provider
Calendar Year Maximum Inpatient Days	30	0
Inpatient Coinsurance	90%	N/A
Outpatient Copayment / Coinsurance	$5	50%
Outpatient Visits per Calendar Year	50	

Mental Health Parity Requirements

As required by California regulations, there is no limit of days or visits for treatment of severe mental illnesses for adults and children, and serious emotional disturbances of a child. Specifically, these mental illnesses are schizophrenia, schizo-affective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive development disorder or autism, anorexia nervosa, bulimia nervosa, and clinically defined serious emotional disturbances of children.

FEE-FOR-SERVICE PRESCRIPTION DRUG BENEFITS

These benefits are provided through Prescription Solutions and are available to all Direct Pay Medical Plan A and Health Net HMO Plan Enrollees.

Prescription Drug Manager

The Fee-For-Service Prescription Drug Plan covers participants who are enrolled in the following Medical Plans:

* Direct Pay Medical Plan A
* Health Net

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan has contracted with ***Prescription Solutions*** to provide a network of conveniently located participating pharmacies and a mail order program. When you have your prescriptions filled at a participating pharmacy or through the mail order program, you save money for yourself and the Plan.

When you need a medication for a short time—an antibiotic for example—it's best to have your prescription filled at a participating retail pharmacy. If you are taking a medication on a long-term basis, it's usually best to have it filled through the mail order program.

Utilization Management

Prescription Solutions also provides the Trust Fund with Drug Utilization Management services. Under this program, certain drugs may be subject to restrictions such as:

* required prior authorization
* maximum daily dose
* maximum quantity limits

You can call the member services number at Prescription Solutions if you need additional information about any restrictions that may apply regarding your prescriptions.

Retail Pharmacy Program

You will receive a prescription drug ID card. When you have a prescription filled at a participating pharmacy and show the pharmacist your ID card, your copayment requirement for up to a 30-day supply **is $5 plus 20%** of the cost of the drug, including the dispensing fee. However, you will not be required to pay more than the full cost of the drug if this is less than the copayment.

If you use a non-participating pharmacy, for example in an emergency, you will need to pay the full cost of the prescription and file a claim with Prescription Solutions for direct reimbursement.

Mail Order Pharmacy Program

Use the mail order prescription drug program when you have prescriptions filled for maintenance drugs (medications you take on an ongoing basis). When you order by mail, you can get up to a 90-day supply. Mail order drugs are delivered directly to your home. The copayment requirements for up to a 90-day supply are:

Generic Drugs	$40
Brand Name Drugs	$60

However, you will not be required to pay more than the full retail cost of the drug.

Covered Drugs

The Plan covers legend drugs that require a written prescription from a physician or dentist. A licensed pharmacist must dispense these prescriptions. Included in Covered Drugs are:

* The following diabetic supplies: blood glucose test strips, insulin cartridges, insulin pre-filled pen with insulin and needle (disposable), insulin vials and syringes and needles, Pen needles, sterile lancets, urine glucose test strips.
* Amphetamines and stimulants only for the treatment of ADD & ADHD.
* Compounds with at least one federal legend or state restricted ingredient.
* Prescription Prenatal Vitamins.

Exclusions

The following expenses are not covered under the Prescription Drug Program:

* Prescriptions obtained at a non-participating pharmacy.
* Prescriptions dispensed by a licensed hospital during confinement (including “take-home” prescriptions).
* Drugs or medications that may be procured without a Physician’s written prescription except as specifically provided for.
* Medications prescribed for experimental or non-FDA approved indications except under limited conditions.
* Diabetic supplies not specifically listed above.
* Any drugs related to the treatment of infertility.
* Appliances or prosthetics.
* Prescriptions for conditions arising out of, or in the course of, employment, including self-employment.
* Any non-drug item.
* Drugs used to promote hair growth.
* Smoking deterrents.
* Drugs for which reimbursement is provided by a governmental agency except to the extent that the Veterans Administration may request reimbursement for prescriptions to treat illness or injury that is not related to service in the Armed Forces.
* Multiple and non-therapeutic vitamins and dietary supplements.
* Health and beauty aids.
* Drugs not Medically Necessary
* Retin-A for anyone over 25 years of age.
* Oral Contraceptives unless they pre-authorized in advance as Medically Necessary.

How to File a Prescription Claim

If you have an emergency and need to fill a prescription at the pharmacy that does not participate with Prescription Solutions, you will need to fill out a Prescription Solutions claim form. The claim form is available on the Prescription Solutions website at www.rxsolutions.com or from the Trust Fund Office.

You will need a pharmacy receipt including: patient name, name and address of pharmacy; date of service, name of medication, NDC number, strength, quantity, Rx number, physician name and phone number, cost and a brief explanation as to why you had to pay out-of-pocket for the medication. Cash register tapes and credit card receipts alone are not acceptable.

Send your claim to:

Prescription Solutions
Attention: Claims Department
P.O. Box 6037
Cypress, CA 90630-0037

Automotive Industries Welfare Plan has determined that the prescription drug coverage under the following prescription drug plan options (the Direct Pay Plan, and the Healthnet HMO) are "creditable" for purposes of Medicare Part D.

"Creditable" means that the value of this Plan's prescription drug benefit is, on average for all Plan Administrators, expected to pay out as much as or more than the standard Medicare prescription drug coverage will pay.

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

Health Reimbursement Arrangement (HRA) Plan

Establishment of the HRA Plan

Effective July 1, 2009, the Automotive Industries Welfare Plan will permit reimbursement of Medical Care Expenses on a nontaxable basis from the Health Reimbursement Arrangement (HRA). The Health Reimbursement Arrangement Plan (HRA Plan or Plan) described in this section is integrated with the Medical Plan provided by Automotive Industries Welfare Fund and is designed to provide reimbursement of certain Eligible Medical Care Expenses for eligible HRA Plan Administrators. The HRA Plan allows reimbursement of Eligible Medical Care Expenses on a tax-free basis.

The HRA Plan is intended to be a tax-exempt employer-provided medical (medical care) reimbursement plan with the intention that it qualify as a medical reimbursement plan within the meaning of Sections 105 and 106 of the Internal Revenue Code of 1986 (Code) and regulations issued thereunder, and as a health reimbursement arrangement (HRA) as defined under IRS Notice 2002-45 and shall be interpreted to accomplish that objective. The HRA is an Employee Welfare Benefit Plan under ERISA. The HRA Plan complies with applicable federal regulations including COBRA, USERRA, FMLA, and HIPAA Privacy and Security.

The HRA Plan is **not** a stand-alone plan and is intended to be made available only in conjunction with the medical benefits of this Automotive Industries Welfare Plan. This means that Employees may not participate in the HRA Plan without also participating in the Medical Plan sponsored by Automotive Industries Welfare Plan.

HRA Definitions

Code: means the Internal Revenue Code of 1986, as amended.

Highly Compensated Individual: an individual defined under Code §105(h), as amended, as a "highly compensated individual" or "highly compensated employee."

HRA: means a health reimbursement arrangement as defined in IRS Notice 2002-45. Since an Employee has no election between excludable benefits and cash, the HRA is not a cafeteria plan. The contributions to the HRA Account are excludable from the HRA Participant's gross income, and are not subject to FICA or FUTA taxes, and the disbursements from the HRA Account to pay for qualifying medical expenses are also excludable from the HRA Participant's gross income. The assets in the HRA Account can be used only to pay the Medical Care Expenses of the HRA Participant and their Dependents. To the extent amounts remain in the HRA Account after an HRA Participant dies, the HRA Account can be used to pay the Medical Care Expenses of a deceased HRA Participant's Dependents.

HRA Account: means the health reimbursement arrangement account described in this section.

HRA Administrator: means the Administrative Office who has the authority and responsibility to administer the HRA Accounts and pay HRA claims.

HRA Participant: means a Class I Bargaining Employee who maintains eligibility and is covered by the direct pay Plan. The Class 1 Employee must work for an employer that has negotiated medical and dental benefits with the Automotive Industries Welfare Plan.

Incurred: means the date the service is provided/furnished, rather than the date the service is billed, is charged for, or is paid. Medical expenses Incurred before an HRA Participant first becomes covered by the HRA Plan are not eligible. However, an eligible medical expense

Incurred during one Period of Coverage may be paid during a later Period of Coverage, provided that the HRA Participant was eligible in the HRA Plan during both Periods of Coverage.

Medical Care Expenses: has the meaning described later in this section.

Period of Coverage: means the Plan Year (which is the Calendar Year), with the following exceptions:

* for Bargaining Employees who first become eligible to participate, it means the portion of the Plan Year (Calendar Year) following the date participation begins; and
* for Bargaining Employees who terminate participation, it means the portion of the Plan Year (Calendar Year) prior to the date participation terminates.

Eligibility (Who can/cannot participate in the HRA Plan?)

You are eligible to participate in the HRA Plan if you are a covered Participant in the Automotive Industries Welfare Plan.

Retirees may **not** access any unused balance in the HRA Account that they accumulated while they were an active Employee.

Please note: you may be responsible for paying income tax on the imputed income value of the benefits provided for a Domestic Partner or the children of your Domestic Partner. You should consult with a tax specialist on this matter.

Initial Effective Date

An Employee will become eligible to participate in the HRA Plan on the first day that the Employee has attained eligibility under the Automotive Industries Welfare Plan.

Participation in the HRA Plan will continue until the HRA Participant is no longer eligible as outlined below.

Accruing an HRA Account Balance

When you become an HRA Participant, an HRA Account will be established in your name. Eligible Medical Care Expenses Incurred by you and your covered Dependents may be reimbursed from the balance in your HRA Account at the time a claim is submitted. This section describes how your HRA Account is developed and how the account is administered by the Fund's Administrative Office.

Contributions to the HRA Account

The Board of Trustees will review the Fund's financial operations on an annual basis, to determine the appropriate HRA Account contribution amount and frequency of contribution based on the reserve level, financial projections, and financial outlook of the Plan.

The current contribution amount is $50 per month and will be made on the first of the month following each month of eligibility.

Nothing herein will be construed to require the Automotive Industries Welfare Plan to maintain any trust fund or to segregate any amount for the benefit of any Employee, and no Employee or other person will have any claim against, right to, security or other interest in any fund, account or asset of the Automotive Industries Welfare Plan from which any payment under the HRA Plan may be made.

Unused Amounts in the HRA Account

If you do not incur enough expenses in a Plan Year (Calendar Year) to use up your HRA Account balance, you will not lose the unused amount in your HRA Account. Any unused amounts in your HRA Account at the end of the year will be carried over into the next calendar year. Eligible Medical Care Expenses Incurred in a previous year or in the current year can be reimbursed from the current balance in your HRA Account, even if all or part of the balance was carried over from the previous Plan Year (Calendar Year).

Upon termination of the Plan (or if you transfer to the HMO), the HRA Participant's coverage ceases. This means that there is no cash out, reimbursements or debits from any remaining balance in that HRA Account.

However, an HRA Participant or the Participant's estate may claim reimbursement of a Medical Care Expense that was Incurred during the Period of Coverage prior to termination of participation provided that the HRA Participant or their estate files a claim by March 31 following the close of the Plan Year (Calendar Year) in which the Medical Care Expenses was Incurred.

Expenses submitted for reimbursement after your participation terminates will not be eligible for reimbursement unless COBRA is elected.

Employee Contributions

There are no Employee or Dependent contributions permitted to the HRA Account.

No Funding Under a Cafeteria Plan

Under no circumstances will the benefits of the HRA Plan be funded with salary reduction contributions, employer flex credit contributions or otherwise under a cafeteria plan.

Reimbursements

All reimbursements payable from the HRA Plan will be paid from the general assets of the Plan. Your HRA Account is a notional (unfunded) bookkeeping record to track, on paper, any contributions credited to your HRA Account and any reimbursements made to you from the account. There are no investment income amounts earned or lost during the Plan Year (Calendar Year) because the account is a notional account. Additionally this Plan does not apply an administrative fee for the use of an HRA Account.

No reimbursement can be made from an HRA Account where the balance is zero.

Forfeitures

Amounts remaining in your HRA Account after HRA Plan participation has ended will be forfeited, except in the event of death. In the event of your death, your participation in the HRA Plan will end. After your death, your Dependents may elect COBRA in order to be entitled to reimbursements from your remaining HRA Account until the earlier of the date the HRA Account reaches a zero balance or the end of the COBRA continuation coverage.

Forfeitures will become the property of the Fund as administered by the Board of Trustees.

Breaks in Eligibility

In the event your eligibility is terminated for a period of more than twelve (12) months and COBRA continuation coverage has not been elected, the HRA Account is automatically forfeited.

In the event you return to work after a break in eligibility of 12 months or less and enroll in the Direct Pay Medical Plan your previously accrued HRA balance will be reinstated.

If you return to work after a break in eligibility of 12 months or less and enroll in the HMO, you will not be able to use your previously accrued HRA funds while enrolled in the HMO Plan. However, the HRA fund balance will be reinstated if and when you re-enroll in the Direct Pay Medical Plan.

Any HRA benefit payments that are unclaimed (e.g., uncashed benefit checks) 12 months after the Period of Coverage in which the Medical Care Expense was Incurred will be forfeited.

There is no cash out option, or reimbursement or debit from any remaining HRA Account balance for any reason including termination of employment due to retirement or death.

The HRA Account is not portable.

Eligible Medical Care Expenses

The Fund reimburses you for "Eligible Medical Care Expenses," as described below. To be considered an "Eligible Medical Care Expense" that qualifies for reimbursement, an expense must:

- be Incurred and claimed while you are eligible for reimbursement in accordance with all provisions of the Plan; and
- be substantiated by filing a written claim with the Fund Office and providing evidence that an Eligible Medical Care Expense was Incurred; and
- not be reimbursable from any other health plan or insurance; and
- be Incurred by you and/or your Dependents for "medical care," as defined in Internal Revenue Code Sections 105 and 213(d).

Medical Care Expenses

In general, Medical Care Expenses include, but are not limited to, amounts for such services as hospitalization, doctors and dentists, and prescription drugs. Such expenses also include amounts you pay for deductibles, copays, coinsurance, as well as premiums for group health plan coverage (provided premiums are not paid through salary reduction contributions under the terms of a Code Section 125 plan or any plan that provides for premium payment with pre-tax dollars), amounts paid for COBRA continuation coverage (COBRA premiums), and amounts paid for Medicare Parts B, C, and D coverage.

Common Medical Care Expenses can also include: acupuncture, contraceptives, chiropractic services, contact lenses/eyeglasses, crutches, dental treatment but not teeth whitening, diabetic supplies, eye examination by an optometrist, device to measure blood pressure, fertility treatment, surgical dressing supplies, elastic bandages like an Ace wrap, hearing aids, immunizations and flu shots, laboratory tests, LASIK eye surgery, tobacco cessation drugs, orthodontia treatment/dental braces, walker/wheelchair and weight loss programs/weight loss drugs only if recommended by a Physician to treat a specific medical condition (e.g. diabetes, obesity, heart disease), and for retirees, the premiums for Medicare medical and prescription drug coverage.

However, not all Medical Care Expenses will be considered "Eligible Medical Care Expenses" that qualify for reimbursement under the Fund. Generally, only Medical Care Expenses within the meaning of Section 213 of the Internal Revenue Code are eligible.

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

Excludable Expenses

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

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

Nondiscrimination

Reimbursements to Highly Compensated Individuals may be limited or treated as taxable compensation to comply with Code § 105(h), as may be determined by the Plan Administrator in its sole discretion.

Filing a Claim for Reimbursement

The following procedures must be followed in order to receive a reimbursement from an HRA Account:

a. **Claims Submission and Substantiation:** A written request to the Fund Office for reimbursement of an Eligible Medical Care Expense from an HRA Account is considered to be a claim. In order to be reimbursed, you must use the Plan's HRA claim form (available from the Administrative Office) and provide applicable receipts, bills, invoices or other statements from the medical provider.

b. A claim for reimbursement of an Eligible Medical Care Expense must be submitted to the HRA Claims Administrator within 12 months of the date the expense was Incurred. After 12 months, the expense will no longer be eligible for reimbursement.

c. Incurred expenses must total at least $100 before they can be submitted for reimbursement. You may include multiple Eligible Medical Care Expenses to be included in a claim in order to reach the $100 minimum. If your claim(s) do not meet or exceed the $100 limit, you may submit one claim per quarter.

d. The **claim form** will request information on the following:
   1. the person or persons on whose behalf Medical Care Expenses have been incurred;
   2. the date the expense was incurred;
   3. a description of the expense incurred;
   4. the amount of the requested reimbursement;
   5. a statement that the expenses submitted for reimbursement have not otherwise been reimbursed; and
   6. bills, invoices, or other statements from an independent third party showing that the Medical Care Expenses have been incurred and the amounts of such expenses, together with any additional documentation that the HRA Claims Administrator may request.

e. If an expense has already been paid or reimbursed by another health plan or insurance, it will not be eligible for reimbursement from this Plan. However, to the extent there is any remaining, unpaid portion of an Eligible Medical Care Expense that was submitted to another health plan or insurer, you may submit the unpaid portion to this Plan for reimbursement.

How to File a Claim:

The Employee should obtain the proper HRA claim form from the Administrator and carefully follow the claim filing instructions on the claim form. Attach applicable receipts, bills, invoices or other statements from the medical provider.

Inability to Locate Payee

If the Plan Administrator is unable to make payment to any Employee or other person to whom a payment is due under the HRA Plan because it cannot ascertain the identity or whereabouts of such Employee or other person after reasonable efforts have been made to identify or locate such person, then such payment and all subsequent payments otherwise due to such Employee or other person will be forfeited following a reasonable time (one year) after the date that any such payment first became due.

Effect of Mistake

In the event of a mistake as to the eligibility or participation of an Employee, or the allocations made to the HRA Account of any Employee, or the amount of benefits paid or to be paid to an Employee or other person, the Plan Administrator or its designee will, to the extent that it deems administratively possible and otherwise permissible under Code §105, the regulations issued thereunder or other applicable law, cause to be allocated or cause to be withheld or accelerated, or otherwise make adjustment of, such amounts as it will in its judgment accord to such Employee

or other person the credits to the HRA Account or distributions to which he or she is properly entitled under the HRA Plan.

Code and ERISA Compliance

It is intended that the HRA Plan meet all applicable requirements of the Code and ERISA, and of all regulations issued thereunder. The HRA Plan will be construed, operated and administered accordingly, and in the event of any conflict between any part, clause or provision of the HRA Plan and the Code and/or ERISA, the provisions of the Code and ERISA will be deemed controlling, and any conflicting part, clause or provision of the Plan will be deemed superseded to the extent of the conflict.

Non-Assignability of Rights

The right of any HRA Participant to receive any reimbursement under the HRA Plan shall not be alienable by the Participant by assignment or any other method and shall not be subject to claims by the HRA Participant's creditors by any process whatsoever. Any attempt to cause such right to be so subjected will not be recognized, except to such extent as may be required by law.

Delta PPO Dental Basic Plan

You are eligible for dental benefits only if you work under a collective bargaining agreement or Subscription Agreement that requires your signatory employer to contribute to the Trust Fund for these benefits. Class 1 Employees must enroll in one of the pre-paid dental Plan options for the first 12 months of eligibility.

If you are eligible for dental benefits, after the initial 12-month period, you may choose among this Plan, the Scheduled Dental Plan described in the next section of this booklet or one of the four Pre-paid Dental Plans. When you enroll in one of the Pre-paid Dental Plans, you will receive an ***Evidence of Coverage*** directly from that Plan which will provide complete details of your benefits and what to do if you have a complaint about your benefits.

Choice of Providers

You may receive services from any dental provider, however it is to your advantage to choose a Delta dentist, in particular one who is in the Delta PPO network.

If you choose a **Delta Dental PPO Dentist**, you will receive all of the advantages of going to a PPO Dentist, and you may have a higher level of benefits for certain services. Payment to a Delta Dental PPO Dentist will be based on the applicable percentage of the lesser of the fee actually charged, the dentist's Allowed Charge on file with Delta Dental, or a fee which the dentist has contractually agreed upon with Delta Dental to accept for treating enrollees under this Plan.

If you go to a **non-Delta Dental Dentist**, Delta Dental cannot assure you what percentage of the charged fee may be covered. Payment for services by a California dentist, or an out-of-state dentist, who is not a Delta Dental Dentist will be based on the applicable percentage of the lesser of the fee actually charged, or the fee that satisfies the majority of Delta Dental Dentists.

Claims for services from non-Delta Dental Dentists may be submitted to Delta Dental at P.O. Box 997330, Sacramento, CA 95899-7330.

A list of Delta Dental PPO Dentists and Delta Dental Dentists can be obtained by calling 800-765-6003. You can also obtain specific information about Delta Dental PPO Dentists and Delta Dental Dentists by using the web site – www.deltadentalins.com or calling the Delta Dental Customer Service department at the number shown in the ***Quick Reference Chart*** at the front of this booklet.

Covered Benefits

The following Benefits are limited to the applicable percentages of dentist's fees or allowances specified below. You are required to pay the balance of any such fee or allowance, known as the "Enrollee co-payment." If the dentist discounts, waives or rebates any portion of the Enrollee co-payment to the Enrollee, Delta Dental only provides as Benefits the applicable allowances reduced by the amount that such fees or allowances are discounted, waived or rebated.

Your Dental Plan covers several categories of Benefits, when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice.

Annual Maximum

Delta Dental will provide payment for these services at the percentage indicated up to a Maximum of $3,000 for each Enrollee in each calendar year. Payment for Implant Benefits for

each Enrollee is limited to a Calendar Year Maximum of $1,250. These maximums will not be applied to pediatric dental care.

Diagnostic and Preventive Incentive Plan Benefits

Delta Dental will pay 80% or 70% (depending on your dentist of choice) of the Covered Fees for Diagnostic and Preventive Benefits during the first calendar year of eligibility.

This percentage increases 10% each consecutive year the dentist is visited to a maximum of 100%. If you do not use your Plan, the percentage remains at the level you reached the previous year. It always drops back to 80% or 70% (depending on your dentist of choice) if you lose eligibility and then become eligible again.

1. 80%-100% if provided by a Delta Dental PPO Dentist
2. 70%-100% if provided by other dentist

Diagnostic - oral examinations; x-rays; examination of biopsied tissue; palliative (emergency) treatment of dental pain; specialist consultation

Preventive - prophylaxis (cleaning); fluoride treatment; space maintainers

Basic Benefits

1. 80% if provided by Delta Dental PPO Dentist
2. 70% if provided by other dentists

Oral surgery - extractions and certain other surgical procedures, including pre- and post-operative care

Restorative - amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)

Endodontic - treatment of the tooth pulp

Periodontic - treatment of gums and bones that support the teeth

Sealants - topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay

Adjunctive General Services - general anesthesia; office visit for observation; office visit after regularly scheduled hours; therapeutic drug injection; treatment of post-surgical complications (unusual circumstances); limited occlusal adjustment

Crowns, Inlays, Onlays and Cast Restoration Benefits

1. 80% if provided by a Delta Dental PPO Dentist
2. 70% if provided by other dentists

Crowns, Inlays, Onlays and Cast Restorations are Benefits only if they are provided to treat cavities which cannot be restored with amalgam, silicate or direct composite (resin) restorations.

Prosthodontic Benefits

1. 80% if provided by a Delta Dental PPO Dentist
2. 70% if provided by other dentist

Construction or repair of fixed bridges, partial dentures and complete dentures are Benefits if provided to replace missing, natural teeth.

Implant Benefits

1. 80% if provided by a Delta Dental PPO Dentist
2. 80% if provided by other dentists

Prosthetic appliances placed into or on bone or the maxilla or mandible (upper or lower jaw) to retain or support dental prosthesis including endosseous, transosseus, subperiosteal, and endodontic implants, implant connecting bars, implant repairs and implant removal.

The maximum payable under this benefit each Calendar Year is limited to $1,250.

Limitations

1. An oral examination is a benefit only twice in a 12-month period while you are eligible under any Delta Dental Plan.
2. Full-mouth x-rays are benefits once in a 36-month period while you are eligible under any Delta Dental Plan.
3. Bitewing x-rays are provided on request by the dentist, but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults age 18 and over, while you are eligible under any Delta Dental Plan.
4. Delta pays for two cleanings or a dental procedure that includes a cleaning each calendar year under any Delta Dental Plan.
5. Routine prophylaxes are covered as a Diagnostic and Preventive Benefit and periodontal prophylaxes are covered as a Basic Benefit.
6. Fluoride treatments are covered twice each calendar year under any Delta Dental Plan.
7. Periodontal scaling and root planing is covered once for each quadrant each 24-month period.
8. Sealant Benefits include the application of sealants only to permanent first molars through age eight and second molars through age 15 if they are without caries (decay) or restorations on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two years of its application.
9. Crowns, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you are an Enrollee under any Delta Dental Plan, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth involved has experienced extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.
10. Prosthodontic appliances are benefits only once every five years, while you are eligible under any Delta Dental Plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental Plan will be made if it is unsatisfactory and cannot be made satisfactory.
11. Delta Dental will pay the above percentage of the dentist's fee for a standard partial or complete denture. A standard partial or complete denture is one made from accepted materials and by conventional methods. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the fee. For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.

12. Implants are Benefits only when conventional fixed or removable prosthesis cannot provide clinically acceptable service and the Enrollee will derive significantly greater benefit from an implant-borne prosthesis.
13. Covered implant procedures are not benefits unless the dentist requests and receives predetermination from Delta Dental. A second opinion may be required from a dentist and at a location selected by Delta Dental before predetermination will be granted.
14. Replacement implants are Benefits only following a five year period after installation of an original implant provided under any Delta Dental Plan.

Exclusions/Services Not Covered

Delta Dental covers a wide variety of dental care expenses, but there are some services for which we do not provide Benefits. It is important for you to know what these services are before you visit your dentist. Delta Dental does not provide benefits for:

1. Services for injuries or conditions that are covered under Workers' Compensation or employer's Liability Laws.
2. Services which are provided to the Enrollee by any Federal or State Governmental Agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.
3. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
4. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.
5. Any Single Procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this Plan.
6. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.
7. Experimental procedures.
8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
9. Anesthesia, except for general anesthesia given by a dentist for covered oral surgery procedures.
10. Grafting tissues from outside the mouth to tissues inside the mouth ("extraoral grafts").
11. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.
12. Replacement of existing restoration for any purpose other than active tooth decay.
13. Intravenous sedation, occlusal guards and complete occlusal adjustment.
14. Orthodontic services (treatment of malalignment of teeth and/or jaws).
15. Diagnostic casts.
16. Posterior composite restorations.
17. Charges for any claim for treatment or services and/or supplies which is not filed within 12 months from the later of the date the expense is incurred or the date of payment under another Plan which is primary. Any exception to the foregoing will be determined solely by the Board of Trustees.

Saving Money on Your Dental Bills

You can keep your dental expenses down by practicing the following:

1. Compare the fees of different dentists;
2. Use a Delta Dental Dentist;
3. Have your dentist obtain predetermination from Delta Dental for any treatment over $300;
4. Visit your dentist regularly for checkups;
5. Follow your dentist's advice about regular brushing and flossing;
6. Avoid putting off treatment until you have a major problem; and
7. Learn the facts about overbilling. Under this Plan, you must pay the dentist your co-payment. You may hear of some dentists who offer to accept insurance payments as "full payment." You should know that these dentists may do so by overcharging your Plan and may do more work than you need, thereby increasing Plan costs. You can help keep your dental Benefits intact by avoiding such schemes.

Your First Appointment

During your first appointment, be sure to give your dentist the following information:

1. Your Delta Dental group number : 2824;
2. The name of the Trust Fund (Automotive Industries Welfare Fund);
3. Primary Enrollee's ID number (which must also be used by Dependents);
4. Primary Enrollee's date of birth;
5. Any other dental coverage you may have.

Predeterminations

After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an estimate of the amount Delta will pay if you are eligible and meet all the requirements of your Plan at the time the treatment you have planned is completed.

In order to receive predetermination, your dentist must send a claim form listing the proposed treatment. Delta will send your dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the form to us for payment when treatment has been completed.

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued if the patient is eligible. Payment will depend on the patient's eligibility and the remaining annual Maximum when completed services are submitted to Delta.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

Reimbursement Provisions

A Delta Dentist will file the claim for you. You do not have to file a claim or pay Delta Dental's co-payment for covered services if provided by a Delta Dental Dentist. Delta Dental of

California's agreement with our Delta Dental Dentists makes sure that you will not be responsible to the dentist for any money we owe.

If the covered service is provided by a dentist who is not a Delta Dental Dentist, you are responsible for filing the claims and paying your dentist. Claims should be filed with Delta Dental of California at P. O. Box 997330, Sacramento, CA 95899-7330 and Delta Dental will reimburse you. However, if for any reason we fail to pay a dentist who is not a Delta Dental Dentist, you may be liable for that portion of the cost. Payments made to you are not assignable (in other words, we will not grant requests to pay non-Delta Dental Dentists directly).

Grievance Procedure and Claims Appeal

If you have any questions about the services received from a Delta Dental Dentist, we recommend that you first discuss the matter with your Dentist. If you continue to have concerns, you may call or write us. We will provide notifications if any dental services or claims are denied, in whole or part, stating the specific reason or reasons for denial. Any questions of ineligibility should first be handled directly between you and your group the Trust Fund Office. If you have any question or complaint regarding the denial of dental services or claims, the policies, procedures and operations of Delta Dental, or the quality of dental services performed by a Delta Dental Dentist, you may call us toll-free at 800-765-6003 contact us on our web site at: www.deltadentalca.org or write us at P. O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department.

If your claim has been denied or modified, you may file a request for review (a grievance) with us within 180 days after receipt of the denial or modification. If in writing, the correspondence must include your group name and number, the Primary Enrollee's name and ID number, the inquirer's telephone number and any additional information that would support the claim for benefits. Your correspondence should also include a copy of the treatment form, Notice of Payment and any other relevant information. Upon request and free of charge, we will provide the Enrollee with copies of any pertinent documents that are relevant to the claim, a copy of any internal rule, guideline, protocol, and/or explanation of the scientific or clinical judgment if relied upon in denying or modifying the claim.

Our review will take into account all information, regardless of whether such information was submitted or considered initially. Certain cases may be referred to one of our regional consultants, to a review committee of the dental society or to the state dental association for evaluation. Our review shall be conducted by a person who is neither the individual who made the original claim denial, nor the subordinate of such individual, and we will not give deference to the initial decision. If the review of a claim denial is based in whole or in part on a lack of medical necessity, experimental treatment, or a clinical judgment in applying the terms of the contract terms, we shall consult with a dentist who has appropriate training and experience. The identity of such dental consultant is available upon request.

We will provide the Enrollee a written acknowledgement within five calendar days of receipt of the request for review. We will make a written decision within 30 calendar days of receipt of the request for review. We will respond, within three calendar days of receipt, to complaints involving severe pain and imminent/serious threat to an Enrollee's health. You may file a complaint with the Department of Managed Health Care after you have completed Delta Dental's grievance procedure or after you have been involved in Delta Dental's grievance procedure for 30 calendar days. You may file a complaint with the Department immediately in an emergency situation, which is one involving severe pain and/or imminent and serious threat to the Enrollee's health.

Scheduled Dental Plan

You are eligible for dental benefits only if you work under a collective bargaining agreement or Subscription Agreement that requires your signatory employer to contribute to the Trust Fund for these benefits. Class 1 Employees must enroll in one of the Pre-paid Dental Plan options for the first 12 months of eligibility.

If you are eligible for dental benefits, after the initial 12-month period, you may choose among this Plan, the Scheduled Dental Plan described in the next section of this booklet or one of the four Pre-paid Dental Plans. When you enroll in one of the Pre-paid Dental Plans, you will receive an Evidence of Coverage document directly from that Plan which will provide complete details of your benefits and what to do if you have a complaint about your benefits.

Benefits provided under the Scheduled Dental Plan

Under this Direct Pay Dental Plan you may go to any licensed dentist of your choice. You will be reimbursed up to the maximum allowance shown in the Plan's ***Schedule of Dental Procedures***, but not more than the billed charges or the dentist's contracted rate with First Dental Health. The Schedule is updated periodically. You may call the Trust Fund Office to request a copy of the most current Schedule.

The Fund has contracted with First Dental Health to provide a PPO Provider Network of Dentists who have agreed to negotiated rates, which will reduce your out-of-pocket expenses. Many covered services provided by a First Dental Health Dentist fall below the Plan's ***Schedule of Dental Procedures*** and therefore are generally covered in full, up to calendar year maximum payment per person of $2,500. This maximum will not be applied to pediatric dental services.

First Dental Health Providers are listed in a separate directory. The listing of Providers is revised periodically. Call First Dental Health before services are rendered to determine if a provider is a First Dental Health Provider at 1-800-334-7244.

The Board of Trustees, at their sole discretion, may authorize benefit payment for alternate dental services deemed necessary and customary for the Course of Treatment. For procedures marked B/R (by report), the Plan determines the allowance based upon the nature and extent of service(s) performed. If the dental procedure is not listed in the ***Schedule of Dental Procedures***, the Plan determines the maximum amount payable based on a dental procedure of equivalent complexity listed in the Schedule.

Covered Dental Services

Those services included in this Plan's Schedule of Dental Procedures includes:

Diagnostic: Provides all the necessary procedures to assist the dentist in evaluating the conditions existing and the dental care required. These services include: office visits, consultations, and diagnostic services.

Oral Surgery: Provides for extractions and other Oral Surgery including pre and post-operative care.

Restorative Dentistry: Provides amalgam, synthetic porcelain and plastic restorations; gold restorations, crowns and jackets (when teeth cannot be restored with a filling material*). However, gold restorations, gold inlays and gold crowns are subject to pre-determination through* the Administrative Office.

Endodontics: Includes necessary procedures for the treatment of non-vital teeth.

Periodontics: Includes procedures necessary for the treatment of diseases of the gums and bones supporting the teeth.

Prosthodontics: Includes bridges, partial and complete dentures, space maintainers and appliances. This coverage is available after you have been covered under this Plan for three (3) consecutive months. If prosthodontic treatment commenced while eligible, coverage will be extended only for the incomplete prosthodontic treatment if this treatment is completed and seated within two (2) calendar months following the month of termination.

Preauthorization of Dental Services

To find out Plan benefits ***in advance***, any time your dentist recommends **$1,000** or more in dental work, have your dentist complete the Dental Claim Form and send it to the Trust Fund Office for preauthorization. (Your benefits will be "preauthorized" assuming you remain eligible for coverage.) The Trust Fund Office will advise you in writing how much the Plan will pay.

The Plan reserves the right to examine all x-rays relating to the proposed Course of Treatment. "*Course of Treatment*" means all treatment performed in the oral cavity during one or more sessions as a result of the same diagnosis, including examinations, x-rays, prophylaxis and any complications arising during such treatment.

Scheduled Dental Plan Exclusions and Limitations

Dental Expense will not include expense incurred:

1. for any charges for which a dentist does not provide treatment;
2. for any disability covered by a Workers Compensation or occupational disease law;
3. for any injury or sickness arising from or sustained in the course of any gainful occupation or employment. This particular limitation shall not apply to covered proprietors or partners, nor to a self-employed Spouse;
4. for any supplies or services:
    - for which no charge is made,
    - for which you are not required to pay,
    - which are furnished by or payable under any plan or law of any Government (Federal or State, Dominion or Provincial) or its political subdivision;
5. for any dental procedure performed for purely cosmetic reasons or with respect to congenital malformations;
6. for orthodontic services, except space maintainers and radiographic x-rays. Note: Certain collective bargaining agreements may provide coverage for separate Automotive Industries Welfare Fund Orthodontic Benefits;
7. for replacement of a satisfactory denture or a denture which can be made satisfactory;
8. for replacement of a denture less than three (3) years after its placement, unless such replacement is made necessary by the initial placement of an opposing full denture;
9. for replacement of a crown or fixed bridge less than three (3) years after its placement unless such replacement is for the purpose of extending a fixed bridge;
10. for dental x-ray examination made because of dental injury resulting from an accident;
11. while the individual is not covered for this benefit;
12. if the procedure is not necessary and customary for the condition being treated;
13. for which payment is made under the terms of this Plan or any other plan;

14. for services restoring tooth structure lost from wear, for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth and related procedures. Such services include, but are not limited to, equilibration and periodontal splinting;
15. for prosthodontic services rendered within the first three consecutive months of eligibility;
16. for sealants on eligible claimants over the age of 15;
17. for charges relating to adjustment of space maintainers if performed within six consecutive months following the installation of space maintainers;
18. for charges relating to post delivery care; conventional clasps, rests and teeth associated with partial dentures;
19. for dental treatment involving the use of gold or more costly materials if such dental treatment could have been provided at a lower cost by means of a reasonable substitute.
20. Charges for any claim for treatment or services and/or supplies which is not filed within 12 months from the later of the date the expense is incurred or the date of payment under another Plan which is primary. Any exception to the foregoing will be determined solely by the Board of Trustees.

Alternate Benefit Provision for Prosthodontics and Dental Implant: The surgical placement of a dental implant (synthetic material including bone grafting material implanted into, onto, or under bone or soft tissue) or the surgical removal of a dental implant are not covered by this Plan. However, in many instances there is more than one method of satisfactory treatment for replacement of missing teeth with fixed or removable prosthodontic appliances. If a dental implant provides a substructure for a prosthetic appliance to replace a missing tooth, and it is determined to be a satisfactory alternative service to conventional fixed prosthodontic appliances, the Plan will extend benefits based on the prosthodontic appliance or implant services having the lesser allowance in the Schedule of Dental Procedures.

Benefits are not available for:

1. any replacement prosthesis placed within the following three (3) years; or
2. implant repair, removal or maintenance procedures.

How to File a Claim

Take this Dental Plan description and the Automotive Industries Welfare Fund Dental Claim Form to your dentist. Ask your dentist to include the Schedule Procedure Number(s) when he completes your Claim Form.

To understand your financial responsibility on the claim, discuss with your dentist his fees, as they compare to Plan exclusions; limitations; and any pre-determination requirements and benefits as shown in the Schedule of Dental Procedures.

When your dental services are completed, the Claim Form should be mailed to the Trust Fund Office as shown on the form. The Claim Form must be signed by both you and the dentist.

Dental Claim Forms are available from your employer, your Union or the Trust Fund Office.

ORTHODONTIC BENEFITS

You are eligible for orthodontic benefits only if you work under a collective bargaining agreement or Subscription Agreement that requires your signatory employer to contribute to the Trust Fund for these benefits.

Coverage commences only after the Employee has been covered under the Automotive Industries Welfare Plan for three (3) consecutive months.

Benefit Payments

If covered by the Plan at the time the initial Orthodontic services (banding) are rendered, the Plan will pay up to a maximum **Orthodontic benefit of $2,500.**

Orthodontic related services such as x-rays, photographs, tracing and study models will be payable subject to the Lifetime Maximum Benefit.

Reimbursement for covered expenses will not be issued during months in which the individual does not have eligibility. If you are enrolled in one of the Pre-paid Dental Plans, this benefit may cover most of your Out-of-Pocket expenses. Submit your claim to the Trust Fund Office for reimbursement.

Orthodontic Plan Exclusions and Limitations

The specified lifetime maximum of approved Orthodontic care is in addition to amounts paid for any service under any of the Automotive Industries Welfare Plan dental options.

Orthodontic expense will not include expenses incurred:

1. for any services for which a Dentist/Orthodontist does not provide treatment;
2. for any disability covered by any Workers' Compensation or occupational disease law;
3. for any injury arising from or sustained in the course of any gainful occupation or employment.
4. For any supplies or services:
5. for which no charge is made;
6. for which you are not required to pay,
7. which are furnished by or payable under any plan, including a dental plan option offered under the Automotive Industries Welfare Plan, or law of any Government (Federal or State, Dominion or Provincial) or its political subdivision.
8. while the individual is not covered by this benefit;
9. if the procedure is not necessary and customary for the condition being treated;
10. Charges for any claim for treatment or services and/or supplies which is not filed within 12 months from the later of the date the expense is incurred or the date of payment under another Plan which is primary. Any exception to the foregoing will be determined solely by the Board of Trustees.

How to File an Orthodontic Claim

Take an Automotive Industries Welfare Plan Dental Claim Form to your Orthodontist. Ask your Orthodontist to show you the treatment plan and related charges when he completes your Claim Form. The Claim Form should be mailed to the Trust Fund Office as shown on the form. The Claim Form must be signed by both you and the Orthodontist. Dental Claim Forms are available from your employer, your Union or the Trust Fund Office.

VISION BENEFITS

Please note that this insured vision coverage is <u>not</u> subject to the requirements of the health care reform law (the Patient Protection and Affordable Care Act (PPACA), as amended by the Health Care and Education Reconciliation Act (HCERA)).

How the VSP Plan Works

Vision care services are provided through an arrangement with Vision Service Plan (VSP). If you obtain your vision care services and supplies from a VSP provider, you receive a higher level of benefits.

Steps for using a VSP provider are as follows:

* Call any VSP participating doctor to make an appointment. Identify yourself as a VSP member and provide your VSP member identification number (usually the last 4 digits of the Social Security Number of the Employee) and the name of the Group Plan (Automotive Industries Welfare Fund).
* If you need assistance locating a VSP participating doctor, call VSP at 800-877-7195 or log on to the VSP website at www.vsp.com and use the "Find a doctor" feature.
* After you have scheduled an appointment, the VSP participating doctor will contact VSP to verify your eligibility and coverage.

When you go for your visit you should pay the VSP vision provider your **$25 copayment** and charges for any costs not covered (see What Is Covered, Optional Extras, and Exclusions from Coverage below). VSP will pay the vision provider directly for the balance of the charges.

Non-VSP Providers

You may choose to use a non-VSP vision provider (any licensed and qualified vision care provider) instead of a VSP provider. However, your benefits will then be limited to the applicable reimbursement allowances (after the $25 copayment).

If you use a non-VSP provider, you will need to pay the doctor in full at the time of your visit, then request reimbursement of the applicable amounts.

Copayment

The $25 copayment applies to each family member regardless of whether you are using a VSP provider or a non-VSP provider. If using a VSP provider, it must be paid at the time services are rendered. If using a non-VSP provider, it will be deducted from your reimbursement. The $25 copayment is due only once each 24 months, for the first service rendered.

What is Covered

The Vision Care Plan provides the benefits described below. You are responsible for the cost of any upgrades or departures from Plan coverage or, if you use non-VSP providers, any costs beyond the reimbursement allowances.

NOTE: You may use either a VSP provider or a non-VSP provider. You may not use your full benefit under a VSP provider and then get a second benefit by going to a non-VSP provider.

Exams

The Plan covers professional fees for an examination of your visual functions once every 24 months.

If you use a VSP provider, VSP pays the full cost after you have paid your copayment. If you use a non-VSP provider, VSP will reimburse you for up to $43 after you have paid the copayment

Eyeglass Lenses

The Plan will cover new eyeglass lenses once every 24 months.

If you use a VSP provider Single Vision, Lined Bifocal and Lined Trifocal lenses are covered in full.

If you use a non-VSP provider, VSP will reimburse you for up to the following amounts after you have paid the copayment:

* Single Vision: up to $26 per pair
* Lined Bifocal: up to $43 per pair
* Lined Trifocal: up to $60 per pair

Frames

The Plan will cover frames for your corrective eyewear once every 24 months.

If you use a VSP provider, VSP will pay an amount up to the Plan allowance of $120 after you have paid the copayment. If you choose a frame whose cost exceeds the Plan allowance, you will be responsible for the additional cost.

If you use a non-VSP provider, VSP will reimburse you for up to $40 after you have paid the copayment.

Elective Contact Lenses

Contact lenses are available once every 24 months in lieu of all other exam, lens, and frame benefits described in this section. Once you get contact lenses under your vision care benefits, you will not be eligible for lens and frame for 24 months.

Contact lenses for any reason other than “necessary” circumstances will be considered elective.

If you use a VSP provider to obtain elective contact lenses, VSP will cover the comprehensive exam in full and pay the VSP allowance of up to $120 for the contact lens fitting and evaluation as well as materials.

If you use a non-VSP provider to obtain elective contact lenses, VSP will reimburse you for up to $43 for the comprehensive exam and up to $100 for the contact lens fitting and evaluation as well as materials.

Necessary Contact Lenses

Contact lenses will be considered necessary if you obtain prior authorization from VSP.

Obtaining Prior Authorization for Coverage of Necessary Contact Lenses

Your eye care provider will need to furnish VSP with the information it needs to decide whether contact lenses are necessary for you. VSP providers will have a pre-certification form they can use for this purpose. Non-VSP providers should contact VSP to find out what is needed.

Once a request for prior authorization is received (assuming it has all the required information), a decision is generally made within 3 to 5 days.

VSP will cover the full cost of necessary contact lenses dispensed by a VSP provider (after you have paid your copayment).

If you use a non-VSP provider to obtain necessary contact lenses, VSP will reimburse you for up to $45 for the exam and up to $210 for materials and other fees (after you have paid the copayment).

If VSP decides contact lenses are not necessary for you, you may appeal the decision as explained in Claims Review Procedures of this booklet. You also have the option of having your lenses covered as elective contact lenses instead.

Low Vision Benefit

Vision care services also include a low vision benefit for severe vision problems not corrected with regular lenses. Benefits under this Plan include, but are not limited to:

* supplemental testing for low vision evaluation
* low vision prescription services
* optical and non-optical aids.

Contact VSP for more information.

Optional Extras

Your vision benefits are designed to cover your vision needs rather than cosmetic materials. If you select any of the following extras, VSP will pay the basic cost of the allowed lenses and frames and you will be responsible for the additional costs of the options:

* a frame that costs more than the Plan allowance
* blended lenses
* oversize lenses
* photochromic lenses or tinted lenses except Pink #1 and Pink #2
* progressive multifocal lenses
* coating of the lens or lenses
* laminating of the lens or lenses
* cosmetic lenses
* optional cosmetic processes
* ultraviolet protected lenses
* low vision care items not covered by your vision care benefits

Additional Discounts

In addition to the benefits stated above, VSP members are eligible for the following with a VSP Provider:

* 20% discount on non-covered lens options
* 20% discount on additional complete pairs of glasses and non-prescription sunglasses (including lens options)
* 15% off cost of contact lens exam (evaluation and fitting)
* discounts on Laser Surgery (only available with a VSP provider)

How To File A Claim for Vision Care Benefits

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

If you use a non-VSP provider, you will need to file a claim for reimbursement of the applicable amount(s). Call VSP at 800-877-7195 to have an Out-of-Network Reimbursement Form mailed or faxed to you (you can also fill out the form online at www.vsp.com and print it out). Mail the completed form with your itemized receipt to VSP at the following address:

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

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

If you have any questions about submitting your claim, contact VSP.

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

ACCIDENT AND SICKNESS DISABILITY BENEFITS

Required Disability Plan Contributions

Certain collective bargaining agreements provide for Disability Plan benefits. The Benefits help in replacing the Employee's daily wage when disabled due to accident or illness. An Employee who is employed under a collective bargaining agreement that provides for Disability Plan benefits and on whose behalf the required contribution has been made, will be automatically covered for this benefit.

Definition of Disabled

To be eligible for this benefit, the Employee must be disabled and prevented by Accident or Illness from engaging in their regular occupation, and is not so engaged while deemed totally disabled. If a Doctor determines that a modified work arrangement is possible, the Employee must work under this arrangement. However, if an employer does not have the work available as prescribed by the Doctor under a modified arrangement, the Employee is still deemed disabled and eligible for Disability Plan benefits under the terms of the Disability Plan.

Limitations

If engaged in any occupation for wages or profit, including modified duty offered in their regular occupation as prescribed by the Employee's Doctor, benefits will be reduced by such amounts. No benefit is allowable while the Employee is unemployed; receiving holiday pay or for any period that the Employee declines to work available modified duty as prescribed by their Doctor.

Disability Plan Benefits

Employees scheduled for work in a covered classification and who are eligible for Disability Plan benefits shall be entitled to a benefit payment for each scheduled work day starting on the:

BENEFITS COMMENCE	DISABILITY CONDITIONS
First work day in which no wage was paid	When disabled due to accident.
First work day in which no wage was paid	When hospital confined as an inpatient (for either an illness or an accident).
Fourth work day in which no wage was paid	When disabled because of an illness that did not require an inpatient confinement.

During any one period of disability, the maximum period of benefit payment under this Disability Plan is 195 days (39 work weeks).

Periods of Disability

The following rules apply in determining what constitutes the same or a separate period of disability for Employees eligible under the Automotive Industries Welfare Fund's Disability Plan.

Same Disability

One period of disability is defined as:

* a disability resulting from the same cause or causes; or
* if the Employee has not returned to full-time active employment for which any wages are paid, a disability period due to a new cause or causes which occurs while the Employee is still on disability due to the initial unrelated cause or causes.

Separate Disability

A disability period due to a new cause or causes will be considered a separate disability only if:

* The disability is due to a cause or to causes entirely unrelated to the previous disability resulting in an extension of eligibility or any of its causes, as determined in the discretion of the Board of Trustees; and
* Either the Employee has returned to active employment and has been eligible for benefits under the Plan for at least three (3) months or the disability involves an inpatient Hospital stay of at least two (2) days.

How Benefits Are Calculated

Benefits are computed at a rate of thirty-five percent (35%) of the actual rate of pay received immediately preceding the entitlement to benefits for each regularly scheduled work day to a maximum of five work days during each week. Provided, however, that the benefits paid by this Disability Plan shall not exceed 80% of the Employee's contracted regular gross pay, including any regular mandatory employer overtime pay, when combined with allowable benefits or income, whether or not applied for, from the following sources:

* Worker's Compensation or similar employee liability benefits;
* Disability payments from any national, state, or local government plans;
* Social Security Act or Railroad Retirement Act disability benefits or the Longshore and Harbor Worker's Compensation Act as it relates to disability benefits;
* Any other disability benefits provided by an employer under this Disability Plan;
* Wages or profit earned from any employment while disabled.

Any bonus or vacation pay received by a disabled Employee shall not be combined with allowable benefits for this purpose.

An Employee may receive employer sick leave during the Disability Plan's three day waiting period when disabled because of an illness without integration with Disability Plan benefits.

NOTE: Federal laws require that F.I.C.A. taxes be deducted from each Disability payment made to an Employee. Federal and State Income Taxes will be deducted if requested by the Employee. After year-end, the Trust Fund Office furnishes each Employee a W-2 form that includes all Disability benefits paid to the disabled member by the Trust Fund in the prior calendar year. **Please note that the IRS may consider disability benefit payments to you as taxable income for the year in which they are paid. Please check with the IRS or with your tax advisor if you have questions about this taxable income.**

Example of Disability Plan Benefit Calculation

Assume the Employee earns $20 per hour ($800 per week) before he become disabled. He applies for State Disability and becomes entitled to a $490 weekly benefit. The Employee is not engaged in any work for wages or profit.

The Employee is entitled to a weekly Disability Plan payment of 35% of their pre-disability wages (35% X $800 = $280) **if** all benefits available to the Employee, including this Disability Plan and other sources are not more than 80% of his pre-disability wages (80% x $800 = $640).

Benefit Source	***Weekly Benefit***
This Disability Plan	$280
State Disability	$490

Benefit Source	*Weekly Benefit*
Wages from work	$ 0
All available benefits	$770*

* Because $770 is **more** than $640, the gross weekly Disability Plan benefits will be reduced to $150, which is $640 **less** $490, payable by State Disability benefits.

Note: Using these Disability Plan benefit calculations, an Employee's weekly Disability Plan benefit entitlement may not be required to be reduced **if** 35% of their pre-disability gross wages when combined with other income does not exceed 80% of their pre-disability gross wages.

If the Employee is covered under the Direct Pay Medical and/or Dental Plan, and overpayments are made under those plans, disability payments may also be reduced by these overpayment amounts.

Claims Procedures for Disability Benefits

Claim forms are available through the Local Union Offices, the employers or the Trust Fund Office.

Part I of the claim form must be completed by the Employee; **Part II** of the claim form must be completed by the employer; and **Part III** of the claim form must be completed by the Doctor when the Employee is claiming disability benefits because of an accident, when hospital confined as an inpatient, when disabled for more than five work days because of an illness or when specifically requested by the Plan. Failure to fully complete all required parts of the claim form by these parties may delay benefits to the Employee.

Claims must be filed within 180 days of the disability.

IMPORTANT

Please attach a copy of check stubs provided by State Disability or Worker's Compensation showing your weekly benefit entitlement with your initial claim submission. Failure to do so may delay benefits available under the Automotive Industries Welfare Fund Disability Plan.

The Board of Trustees may require the Employee to submit to examination by one or more Doctors of its choice and may set other reasonable requirements on which to base a determination for benefit payment.

If you have any questions about your benefits or how to prepare and submit a claim, they should contact the Administrative Office.

Burial benefit

This Burial Benefit is administered and partially insured by ING. This Burial Benefit pays a benefit to you or your designated beneficiary upon your death or the death of your Dependent. A benefit is also payable to you upon dismemberment. ***You are eligible for this benefit whenever you are eligible for Direct Pay Medical Plan A benefits or one of the HMO Medical Plans.***

You may request an ***Evidence of Coverage*** booklet from ING or from the Trust Fund Office for more complete information about this benefit. The following are the Burial Benefit amounts:

Schedule of Benefits

Employee Burial Benefit	$2,500
* Dependent Burial Benefit (Spouse and Dependent Child(ren))	$2,500

* *Benefit is available for Dependent Children up to age 21 at the time of death.*

Payment of Benefit

Upon proof of death, payment will be made to the beneficiary or beneficiaries named in writing by you. Please note "proof of death" means the original death certificate showing the actual cause of death. We cannot accept a photocopy and the death certificate cannot be returned.

Unless you designate otherwise, payment will be made as follows:

1. If more than one beneficiary is named, each will be paid an equal share. If any named beneficiary dies before you, you should complete the proper forms with the Trust Fund Office to designate a replacement beneficiary(s).
2. If no beneficiary is named, or if no named beneficiary survives you, the benefit will be paid to your surviving relatives in the following order:
   - all to your surviving Spouse or Domestic Partner; or
   - if your Spouse does not survive you, in equal shares to your surviving children; or
   - if no child survives you, in equal shares to your surviving parents; or
   - to the executors or administrators of your estate.

However, the Plan may, at its option, may pay your benefit to any party it deems to be entitled to such payment because of your burial expense.

You may change your beneficiary at any time by contacting the Trust Fund Office for the appropriate form and returning it upon completion. The change of beneficiary will take effect as of the date that you signed the form, even if you have since died.

You and your Dependent's Burial Benefit will be reduced by the amount of personal life insurance in force, if any, issued in accordance with the Conversion Privilege described below.

Conversion Privilege with Respect to Employee Burial Benefit

If you have been eligible for the Employee Burial Benefit for at least three years when you are no longer eligible for the Employee Burial Benefit and your insurance terminates, then you may convert your Employee Burial Benefit to a personal life insurance policy without evidence of insurability. To convert your Employee Burial Benefit, you must, within 31 days of the termination of your group insurance:

* make a written application to ING; and

* pay the premium required for personal life insurance for your age and class of risk.

No disability or supplementary benefits will be included. The personal policy will be effective on the 32nd day after your Plan coverage terminates. At your option, the personal life policy may be preceded by a single premium one-year term life insurance policy, subject to the same conditions.

If your coverage terminates due to this benefit being terminated by either ING or the Plan, the benefit will be reduced by any amount for which you are or become eligible under any other group life insurance policy within 31 days of termination of insurance. However, in no event will payment be more than $2,000.

If you convert to a personal life insurance policy, you may later surrender the personal policy to ING and become entitled to benefits through the *Extension of Burial Benefit During Disability For Employees*. All conditions of the Extension must be met and you must disclaim all benefits under the personal policy except refund of premium.

If you die within the 31 day conversion period, ING will, upon receipt of due proof of your death, pay the amount of insurance you were entitled to convert.

Extension of Burial Benefit During Disability of Employees

While you are Totally Disabled, your Employee Burial Benefit will be extended without premium payments if:

* the Total Disability begins while you are eligible for the Employee Burial Benefit and before you are age 60; and
* proof of Total Disability is submitted to the Trust Fund Office within 12 months after you were deemed Totally Disabled, and once each year thereafter as required by the Plan.

Your Employee Burial Benefit, in force on the date your coverage terminates, will be paid to your designated beneficiary if:

* you are Totally Disabled and die prior to your 70th birthday;
* your death occurs within a period equal to the period during which you were insured under ING, and
* your Total Disability is continuous from the date of coverage termination to the date of your death.

The amount of your insurance in force during the Extension period will not exceed the Employee Burial Benefit amount in force at the beginning of the Extension. However, the amount will be reduced in the following instances:

* on account of any change in your insurance classification or in the terms of the policy with ING which would have effected a reduction in the amount of your insurance if you had not been disabled; and
* by any amount for which you become insured under any other group life insurance plan which replaces the policy or replaces coverage for your employer unit.

In no event will the benefit amount be reduced because of any change in classification resulting from the disability which qualifies you for the Extension.

The Extension will cease on the earliest of:

* the date you cease to be Totally Disabled or fail to furnish satisfactory proof of disability as required by the Plan;
* the date you attain your 65th birthday; or

* the date you become insured without limitation as to the disabling condition under a group life insurance plan which replaces the policy with ING or replaces coverage for your employer unit.

If you are no longer eligible, you can convert as outlined under Conversion Privilege.

Written notice of death of an Employee whose insurance is being continued under the Extension must be furnished to the Fund Office within 12 months after the date of death. If notice of death as required is not given, the Plan will not be liable for any payment on account of such death.

General Provisions

Alteration of Contract. Subject to the laws of the state in which the policy is delivered, this contract may at any time be amended and changed by written agreement between ING and the Plan. Any amendment to this contract shall be binding on all persons insured under the policy whether they became insured under the policy prior to or on or after the effective date of the amendment.

Entire Contract; Changes. The policy, the application of the Policy holder and individual applications, if any, of the individuals constitute the entire contract between the parties, and any statement made by the Plan or by any individual shall, in absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Plan, except a fraudulent misstatement, be used at all to void the policy after it has been in force for two years from the date of its issue, nor shall any such statement of any individual eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred, as defined in the policy, commencing after the insurance coverage with respect to which claim is made has been in effect for two years from the date it became effective, nor unless a copy of the application containing the statement is or has been furnished to the claimant.

No change in policy shall be valid unless approved by an executive officer of ING and unless such approval be endorsed thereon or attached thereto. No agent has authority to change the policy or to waive any of its provisions.

Claims Forms. When ING receives a notice of claim, forms will be sent to you for providing ING proof of loss. ING will send these forms within 15 days after receiving a notice of claim. If ING does not send the forms within 15 days, you may submit any other written proof which fully describes the nature and extent of your claim.

Proof of Loss. Written proof of loss must be sent to ING within 90 days after the date of such loss. If such proof cannot be given by the time it is due, this will not affect any claim if: (1) it was not reasonably possible to give proof within the required time; (2) proof is given as soon as possible; but (3) not more than a year after the proof is due, unless the claimant is legally incapable.

Physical Examination and Autopsy. ING reserves the right to: (1) examine any claimant; and (2) to make an autopsy, in case of death, if it is not forbidden by law.

Any such examinations will be at the expense of ING.

Legal Actions. Legal actions cannot be taken against ING:

1. sooner than 60 days after due proof of loss has been furnished; or
2. after the shortest period allowed by the laws of the state where the policy is delivered.

This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy.

EMPLOYEE LIFE INSURANCE

This benefit is only available to Employees who work under collective bargaining agreements or Subscription Agreements that call for an additional employer contribution specifically to pay for this benefit.

The Life Insurance Benefit is administered and partially insured by ING. The Life Insurance Benefit pays a benefit to your designated beneficiary upon your death. An additional benefit is payable to either you or your designated beneficiary upon your accidental death or upon your accidental dismemberment.

The Life Insurance Benefit is paid in addition to any Burial Benefit you may be entitled to based upon your enrollment in one of the medical coverage options offered under the Medical Plan A.

Employee Life Insurance Benefit

*You should refer to your **Certificate of Coverage** from ING for complete detail about your life insurance benefits.*

If you are eligible for Life and AD&D benefits, the amount of the benefit will vary depending on the employer contribution negotiated under the terms of the collective bargaining agreement or Subscription Agreement with your signatory employer.

You will receive a *Certificate of Coverage* from ING which will show the amount of your benefit. The amounts that can be negotiated by your employer are $10,000, $25,000, $50,000, $75,000 or $100,000.

The Employee Life Insurance Benefit will only be paid upon receipt of due proof of death.

Payment will be made to the beneficiary or beneficiaries named in writing by you. The beneficiary/ beneficiaries you name for your Life Insurance Benefit must be the same as those named for your Burial Benefit. Unless you designate otherwise, payment shall be made as follows:

* If more than one beneficiary is named, each will be paid an equal share. If any named beneficiary dies before you, you should complete the proper forms with the Trust Fund Office to designate a replacement beneficiary(s).
* If no beneficiary is named, or if no named beneficiary survives you, the benefit will be paid to your surviving relatives in the following order:
    - all to your surviving Spouse; or
    - if your Spouse does not survive you, in equal shares to your surviving children; or
    - if no child survives you, in equal shares to your surviving parents; or
    - to the executors or administrators of your estate.

However, ING may, at its option, may pay up to $2,000 of your benefit to any party it deems to be entitled to such payment because of your burial expense.

You may change your beneficiary at any time by contacting the Trust Fund Office for the appropriate form and returning it upon completion. The change of beneficiary will take effect as of the date that you signed the form, even if you have since died.

If a beneficiary is a minor who does not have a legal guardian, ING may, until such a guardian is appointed, pay the person it deems to be caring for and supporting him. Such payment will be in monthly installments and of not more than $50 per installment.

You may elect to have your Employee Life Insurance Benefit paid, upon your death, in a lump sum or to have all or part of your Employee Life Insurance Benefit paid in installments. If you have elected a lump sum payment, any beneficiary may change that election to installments after you die. An installment arrangement that yields installments of less than $20 is not allowed.

Conversion Privilege

If or when you are no longer eligible for the Employee Life Insurance Benefit and your insurance terminates, then you may convert your Employee Life Insurance Benefit to a personal life insurance policy. To convert your Employee Life Insurance Benefit, you must, within 31 days of the termination of your group insurance:

* make a written application to ING; and
* pay the premium required for personal life insurance for your age and class of risk.

If you do so, ING will issue to you a personal life insurance policy and the following provisions will hold:

* The personal policy will be issued without evidence of insurability.
* The personal policy will be on one of the life insurance policy forms, except term insurance, then customarily issued by The ING.
* The personal policy will be for the same amount as the Employee Life Insurance Benefit under the Plan.

However, if your coverage terminates due to this benefit being terminated by either ING or the Plan, you will not be able to convert your Life Insurance Benefit.

At your option, the personal life policy may be preceded by a single premium one-year term life insurance policy, subject to the same conditions.

If you convert to a personal life insurance policy, you may later surrender the personal policy to ING and become entitled to benefits through the Extension of Life Insurance During Disability For Employees. All conditions of the Extension must be met; and you must disclaim all benefits under the personal policy except refund of premium.

If you die within the 31 day conversion period, ING will, upon receipt of due proof of your death, pay the amount of insurance you were entitled to convert.

Accidental Death & Dismemberment for Employees

ING will pay a benefit according to the Schedule shown below if:

* you suffer accidental bodily injury while your insurance is in force;
* a loss results directly from such injury, independent of all other causes; and
* such a loss occurs within 90 days after the date of the accident causing the injury.

The following will summarize the losses for which there is a benefit payable and the amount of that benefit. No benefit is payable for any loss which is not shown in the following Schedule.

Schedule of Accidental Death and Dismemberment Benefits

Description of Loss	***Benefit***
Loss of life	Maximum Benefit

Schedule of Accidental Death and Dismemberment Benefits

Description of Loss	*Benefit*
Loss of a hand	One-Half the Maximum Benefit
Loss of a foot	One-Half the Maximum Benefit
Loss of an eye	One-Half the Maximum Benefit
More than one of the above resulting from one accident	Maximum Benefit

Loss of a hand or foot means that it is completely cut off at or above the wrist or ankle joint. Loss of an eye means the sight in the eye: (1) is completely lost; and (2) cannot be recovered or restored.

No benefit will be paid for loss caused or contributed to by:

* sickness;
* disease;
* any medical treatment for sickness or disease;
* any infection, except a pyogenic infection of an accidental cut or wound;
* war or any act of war, whether war is declared or not;
* any injury received while in any armed service of a country which is at war or engaged in armed conflict;
* any intentionally self-inflicted injury, suicide or suicide attempt, whether sane or insane; or
* commission of or attempt to commit assault or felony.

You may change your beneficiary at any time by contacting the Trust Fund Office for the appropriate form and returning it upon completion. The change of beneficiary will take effect as of the date that you signed the form, even if you have since died.

General Provisions

Alteration of Contract. Subject to the laws of the state in which the policy is delivered, this contract may at any time be amended and changed by written agreement between ING and the Plan. Any amendment to this contract shall be binding on all persons insured under the policy whether they became insured under the policy prior to or on or after the effective date of the amendment.

Entire Contract; Changes. The policy, the application of the Policy holder and individual applications, if any, of the individuals constitute the entire contract between the parties, and any statement made by the Plan or by any individual shall, in absence of fraud, be deemed a representation and not a warranty. No such statement shall be used in defense to a claim hereunder unless it is contained in a written application, nor shall any such statement of the Plan, except a fraudulent misstatement, be used at all to void the policy after it has been in force for two years from the date of its issue, nor shall any such statement of any individual eligible for coverage under the policy, except a fraudulent misstatement, be used at all in defense to a claim for loss incurred, as defined in the policy, commencing after the insurance coverage with respect to which claim is made has been in effect for two years from the date it became effective, nor unless a copy of the application containing the statement is or has been furnished to the claimant.

No change in policy shall be valid unless approved by an executive officer of ING and unless such approval be endorsed thereon or attached thereto. No agent has authority to change the policy or to waive any of its provisions.

Physical Examination and Autopsy. ING reserves the right to: (1) examine any claimant; and (2) to make an autopsy, in case of death, if it is not forbidden by law. Any such examinations will be at the expense of ING.

Legal Actions. Legal actions cannot be taken against ING: (1) sooner than 60 days after due proof of loss has been furnished; or (2) after the shortest period allowed by the laws of the state where the policy is delivered. This is 3 years after the time written proof of loss is required to be furnished according to the terms of the policy.

CLAIMS AND APPEALS PROCEDURES UNDER THE DIRECT PAYMENT PLAN

A claim for benefits is a request for Plan benefits made in accordance with the Plan's claims procedures. These procedures for the Direct Pay Medical Plan A are described in this section. For the procedures applicable to your Managed Health Network (MHN) benefits or to your HMO Plan (if you are enrolled in an HMO), please refer to the applicable ***Evidence of Coverage*** brochure. This section also describes the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

If you are enrolled in the Delta Dental PPO Plan or the Vision Plan administered by VSP you should first appeal through the appeals process provided by Delta and VSP. If your appeal is denied, you may then appeal directly to the Board of Trustees as described in this section.

Eligibility Disputes

If your claim is denied because you are not shown as eligible in the records of the Trust Fund Office, your eligibility status will be resolved by the Trust Fund Office, working with the Preferred Provider Organization (PPO), your HMO, United Behavioral Health, or any other service provider as necessary, in accordance with the time lines described below, depending on the classification of your claim as either Urgent, Pre-Service or Post Service.

How to File a Claim for Services That Have Already Been Received

A claim form may be obtained from your Union office or the Trust Fund Office by calling:

(800) 635-3105 or (510) 836-2484.

The following information must be completed in order for your request for benefits to be a claim, and for the Trust Fund Office to be able to process your claim.

Participant completes

* Participant name
* Patient name
* Patient Date of Birth
* SSN of Participant
* If treatment is due to accident, accident details, including how, when and where the accident occurred. (You may be required to sign a Third Party Liability Agreement to reimburse the Plan if you recover damages.)
* Information on other insurance coverage, if any, including coverage that may be available to your Spouse through his or her employer or to your Dependent Children through your ex-Spouse's and/or their step-parent's employer

Provider completes

* CPT-4 (the code for physician services and other health care services found in the Current Procedural Terminology, as maintained and distributed by the American Medical Association)
* ICD (the diagnosis code found in the International Classification of Diseases, 9th Edition, Clinical Modification as maintained and distributed by the U.S. Department of Health and Human Services)

* Date of Service
* Number of Units (for anesthesia and certain other claims)
* Billed charges (bills must be itemized with all dates of Physician visits shown)
* Federal taxpayer identification number (TIN) of the provider and National Provider Identifier (NPI) of the provider
* Provider's billing name, address, phone number and professional degree or license
* Provider's signature

PPO providers should follow the "Claim Submission" instruction shown on your Direct Pay Medical Plan A Identification card. All Non-PPO provider claims should be filed with the Trust Fund Office at the following address:

Automotive Industries Welfare Fund
P.O. Box 23263
Oakland, California, 94623-0263

When Claims Must be Filed

Claims for services that have been received should be filed as soon as reasonably possible but they must be submitted within 12 months from the later of the date the expense is incurred or the date of payment under another Plan which is primary. Any exception to the foregoing will be determined at the sole discretion of the Board of Trustees.

Urgent Care and Pre-Service Claims must be submitted to the Review Organization by phone. They are not to be submitted via the US Postal service.

All Urgent and Pre-Service Claims should be submitted to
Anthem Blue Cross Utilization Review Department by Phone at: (800) 274-7767

All Urgent and Pre-Service Claims for Mental Health and Substance Abuse benefits should be submitted to the Managed Health Network listed on the Quick Reference Chart (see page viii).

Please note that the Urgent Care Claims procedures do not apply to Emergency care. If you experience an Emergency Medical Condition, such as acute onset of chest pain, major trauma, or sudden shortness of breath, you should go to the nearest hospital emergency room. *The charges for these services will be submitted as Post-Service Claims.*

Burial Benefit and Life Insurance and AD&D claims should also be filed with the Trust Fund Office no later than one year after the death or accident. Claim forms are available from your Union office or you may call the Trust Fund Office at (800) 635-3105. In the event of death, certified copy of the death certificate must accompany the claim form.

Authorized Representatives

An authorized representative, such as your Spouse, may complete the claim form for you if you have previously designated the individual to act on your behalf. A form can be obtained from the Trust Fund Office to designate an authorized representative. The Plan may request additional information to verify that this person is authorized to act on your behalf.

A health care professional with knowledge of your medical condition may act as an authorized representative in connection with an Urgent Care Claim without you having to complete the special authorization form.

Direct Pay Medical Plan A Benefits

The claims procedures for Direct Pay Medical Plan A benefits will vary depending on whether your claim is for a Pre-Service Claim, an Urgent Care Claim, a Concurrent Claim, or a Post-Service Claim. The terms are defined in the General Definitions Section of this booklet (see page 93). Disability and Burial Benefit Claims also require different procedures.

Pre-Service Claims

Pre-Service medical claims should be submitted by your provider to:

Anthem Blue Cross Prudent Buyer by phone at (800) 274-7767

You must certify all services for **mental health** or **substance abuse** by **calling Managed Health Network (MHN) at (800) 748-2559.** These services are only covered by the Plan when they are provided by United Behavioral Health contracted doctors and facilities. ***Exception***: Kaiser enrollees must receive all mental health benefits from Kaiser.

If your provider improperly files a Pre-Service Claim, the Review Organization will notify you and/or your provider as soon as possible but not later than five days after receipt of the claim, of the proper procedures to be followed in filing a Claim. Notice of an improperly filed Pre-Service Claim will only be sent if the claim includes (i) your name, (ii) your specific medical condition or symptom, and (iii) a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a Claim.

For properly filed Pre-Service Claims, you and your doctor will be notified of a decision within 15 days from receipt of the Claim unless additional time is needed. The time for response may be extended up to 15 days if necessary due to matters beyond the control of the Review Organization. If an extension is necessary, you will be notified prior to the expiration of the initial 15-day period of the circumstances requiring the extension of time and the date by which a decision is expected to be rendered.

If an extension is needed because the Review Organization needs additional information from you, the extension notice will specify the information needed. In that case you and/or your doctor will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). The Review Organization then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination.

Note: A determination on a Pre-Service Claim by the Review Organization is not a guarantee of benefits nor is it a claim payment determination.

Urgent Care Claims

If your physician improperly files an Urgent Care Claim, the Review Organization will notify you and/or your physician as soon as possible but not later than 72 hours (scheduled to be 24 hours beginning on January 1, 2012) after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a Claim.

Generally, the Review Organization will respond to you and your doctor with a determination as soon as possible, taking into account the medical exigencies, but not later than 72 hours (scheduled to be 24 hours beginning January 1, 2012) after receipt of the Claim.

However, if an Urgent Care Claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, the Review Organization will notify you or your doctor as soon as possible, but not later than 72 hours (scheduled to be 24 hours beginning January 1, 2012) after receipt of the claim, of the specific information necessary to complete the claim. You and/or your doctor must provide the requested information not later than 48 hours after receiving the request for the information. If the information is not provided within that time, your claim will be denied. Notice of the decision will be provided no later than 48 hours after the Review Organization receives the specified information, but only if the information is received within the required time frame.

Note: A determination on an Urgent Care Claim by the Review Organization is not a guarantee of benefits nor is it a claim payment determination

Concurrent Claims

A reconsideration of a benefit with respect to a Concurrent Claim that involves the termination or reduction of a previously approved benefit (other than by Plan amendment or termination), will be made by Anthem Blue Cross (for inpatient care), MHN (for mental health or substance abuse) or the Trust Fund Office in consultation with an independent review organization if appropriate (for other services), as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved urgent care treatment will be acted upon by the review organization within 72 hours (scheduled to be 24 hours beginning January 1, 2012) of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment. A request to extend approved treatment that does not involve urgent care will be decided according to pre-service or post-service timeframes, whichever applies.

Note: A determination on a Concurrent Claim by the Review Organization is not a guarantee of benefits nor is it a claim payment determination

Post-Service Claims

The procedure to follow for filing Post-Service Claims is described in this section under **How to File a Claim for Services That Have Already Been Received**. Be sure to check the claim form to be certain that all applicable portions of the form are completed and that you have submitted all itemized bills. By doing so, you will speed the processing of your Claim. You do not have to submit an additional claim form if your bills are for a continuing illness and you have filed a signed claim form within the past calendar year. Mail any further itemized bills or statements for covered medical services, which include all required information as described above in "How to File A Claims" to the Trust Fund Office as soon as you receive them.

Ordinarily, you will be notified of the decision on your Post-Service Claim within 30 days from the Plan's receipt of the Claim. The Plan may extend the period once for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period of the circumstances requiring the extension of time and the date by which the Plan expects to render a decision.

If the Plan needs additional information from you, your claim will be denied and the Plan will notify you of the denial, state the reason for the denial and specify the additional information needed. However, if you submit the necessary information within 45 days after receipt of the notification of the denial, there is no need to file a new claim. Once the Plan receives this

information, it will make a decision within 15 days on the Post-Service Claim and notify you of the determination.

Burial Benefit Claims

In the event of death, the death must be reported to the Trust Fund Office. The Trust Fund Office will request a certified death certificate and a completed Proof of Death form and any required information if a beneficiary is not designated or if no named beneficiary survives you. Once this information is received by the Trust Fund Office, the Plan will make a decision on Burial Benefit Claims and notify you of the decision within 90 days of receipt of the claim by the Trust Fund Office. If the Plan requires an extension of time due to matters beyond its control, it will notify you of the reason for the delay and the date by which it expects to render a decision. This notification will occur before the expiration of the 90-day period. The period for making a decision may be delayed an additional 90 days.

Notice of Decision

You will be provided with written notice of a denial of a Claim, whether denied in whole or in part. Notice will be sent by Anthem Blue Cross or MHN for all Urgent Care and Pre-Service Claims. Notice will be sent by either the Trust Fund Office, Anthem Blue Cross or MHN for Concurrent Claims, depending on the type of service being received. Notice will be sent by the Trust Fund Office for all Post-Service Claims processed by the Direct Payment Plan. The notice will state.

* The specific reason(s) for the determination;
* Reference to the specific Plan provision(s) on which the determination is based;
* A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
* A description of the appeal procedures and applicable time limits;
* A statement of your right to file a request for an External review or, for an eligibility dispute, file a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
* If an internal rule, guideline, protocol or other similar criterion was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon written request at no charge;
* If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon written request at no charge.

For ***Urgent Care Claims***, the notice will describe the expedited review process applicable to Urgent Care Claims. The notice of determination for Urgent Care Claims will be made in writing or orally and followed with written notification within 3 days thereafter.

Life Insurance and AD&D Claim

When ING receives a notice of claim, forms will be sent to you for providing ING proof of loss. ING will send these forms within 15 days after receiving a notice of claim. If ING does not send the forms within 15 days, you may submit any other written proof which fully describes the nature and extent of your claim. Written proof of loss must be sent to ING within 90 days after the date of such loss. If such proof cannot be given by the time it is due, this will not affect any claim if (1) it was not reasonably possible to give proof within the required time; (2) proof is

given as soon as possible; but (3) not more than a year after the proof is due, unless the claimant is legally incapable.

ING will make a decision on Life Insurance Benefit Claims and notify you of the decision within 90 days of receipt of the claim by the Trust Fund Office. If ING requires an extension of time due to matters beyond their control, they will notify you of the reason for the delay and the date by which they expect to render a decision. This notification will occur before the expiration of the 90-day period. The period for making a decision may be delayed an additional 90 days.

Disability Claim

An appeal must be made within 60 days of the date the Employee receives the letter denying his claim. The Board of Trustees will review the claim and appeal promptly. It will advise the Employee of its decision in writing, setting out specific reasons for the decision with specific references to pertinent Disability Plan provisions on which the decision is based. This written decision will be sent to the Employee not later than 60 days after its receipt of the written appeal, unless special circumstances require an extension of time for processing the appeal, or obtaining more information, or conducting an investigation of the facts. In no event will the written decision be sent later than 120 days after receipt by the Board of Trustees of the written appeal.

Request for Review of Denied Claim

If your claim is denied in whole or in part, or if you disagree with the decision made on a claim, you may ask for a review. Your request for review must meet the following criteria:

* made in writing
* state the reason(s) for disputing the denial;
* accompanied by any pertinent material not already furnished to the Plan; and
* submitted within 180 days after you receive notice of denial (90 days for Death).

The following describes how to make appeals involving an adverse determination:

Urgent Care Claim:	Call Anthem Blue Cross at (800) 274-7767 or MHN at (800) 748-2559 (depending on which organization made the determination).
Pre-Service Claim:	Call Anthem Blue Cross at (800) 274-7767 or MHN at (800) 748-2559 (depending on which organization made the determination).
Post Service Claim:	Submit to the Trust Fund Office at ATPA Health Benefit Appeal Department P.O. Box 1306 Alameda, CA 94501-0137 or FAX To (510) 217-9580
Concurrent Claim:	send to either Anthem Blue Cross, MHN or the Trust Fund Office, depending on which organization made the adverse determination.
Burial Benefit Claim:	Submit to the Trust Fund Office. (Same as Post Service Claim address.)
Disability Claim:	call the Trust Fund Office at (800) 635-3105 or (510) 836-2484

Failure to file an appeal that meets all of these criteria will constitute a waiver of your right to a review of the denial of your Claim.

Review Process

You have the right to submit comments, documents, records and other information in support of your Claim for benefits. Upon written request and free of charge you will be provided with reasonable access to and copies of all documents, records and other information relevant to your Claim.

Upon request, you will be provided with the identification of medical or vocational experts, if any, that gave advice to the Plan on your Claim, without regard to whether their advice was relied upon in deciding your Claim.

Urgent Care Claim Appeals

Urgent Care Claim appeals should be submitted to Anthem Blue Cross (or MHN if they were involved in the original decision). Your appeal will be reviewed by a different person at Anthem Blue Cross (or MHN) than the one who made the original decision and who is not a subordinate of the person who denied your Claim. If your Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental) an independent health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The reviewer will not give deference to the initial adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you relating to the Claim.

If your Urgent Care Claim appeal is denied by Anthem Blue Cross, the Fund offers you the opportunity to voluntarily re-submit your appeal under the Pre-Service Claim rules directly to the Trust Fund Office to be re-reviewed by the appeals sub-committee of the Board of Trustees. The Board of Trustees will review your Claim and notify you of the final determination within 30 days. If your Claim was denied on the basis of a medical judgment, an independent health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The reviewer will not give deference to any prior adverse benefit determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by you relating to the Claim.

Pre-Service Claim Appeals

Pre-Service Claim appeals can be submitted to Anthem Blue Cross or they can be filed with the Trust Fund Office. If appropriate, the Trust Fund Office will send the appeal to an independent review organization. If your Claim was denied on the basis of a medical judgment, an independent health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The appeals sub-committee of the Board of Trustees will then review all relevant information and make a determination on your appeal within 30 days of receipt of the appeal by the Trust Fund Office.

Post-Service Claim Appeals

Post-Service Claim appeals will be reviewed by the Board of Trustees at their next regularly scheduled meeting as described below. The appeal must be submitted in writing to the Board of Trustees and must include the patient's name, participant's name, a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees, the date of the Adverse Benefit Determination and the basis of the appeal. If your Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), an independent health care professional who has appropriate training and experience in a relevant field of medicine will be consulted.

Timing of Notice of Decision on Appeal

* **Urgent Care Claim Appeals**: You will be sent a notice of a decision on appeal by Anthem Blue Cross as soon as possible but no later than 72 hours of receipt of the appeal by the Anthem Blue Cross. If Anthem Blue Cross denies your appeal, you may request a review directly by the Board of Trustees, as described above.
* **Pre-Service Claim Appeals**: You will be sent a notice of decision on appeal by the Trust Fund Office within 30 days of receipt of the appeal by the Trust Fund Office.
* **Post-Service Claim Appeals**: Ordinarily, decisions on appeals involving Post-Service Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of your request for review. However, if your request for review is received in the Trust Fund Office within 30 days of the next regularly scheduled meeting, your request for review may be considered at the second regularly scheduled meeting following receipt of your request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance if this extension will be necessary. Once a decision on review of your claim has been reached, you will be notified by the Trust Fund Office of the decision as soon as possible, but no later than 5 days after the decision has been reached.
* **Burial Benefit Claims**: The decision will be made in the same manner as for Post-Service Claims.

Notice of Decision on Appeal

The decision on any appeal of your claim will be given to you in writing. The notice of a denial of a Claim on review will state:

* The specific reason(s) for the determination;
* Reference to the specific Plan provision(s) on which the determination is based;
* A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon written request and free of charge;
* A statement of your right to file a request for an External review or, for an eligibility dispute, file a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
* If an internal rule, guideline, protocol or similar criterion was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon written request at no charge;
* If the determination was based on medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your claim, or a statement that it is available upon written request at no charge.
* Following issuance of the written decision of the Board on an appeal, you may file a request for an External review or, for an eligibility dispute, file a civil action under ERISA Section 502(a).

What is Not a Claim

The following are examples of interactions you may have with the Plan, the Trust Fund Office or service providers to the Plan that are not subject to the timelines and requirements of this section.

* Simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim will not be treated as a claim for benefits.

* A request for a determination regarding the Plan's coverage of a medical treatment or service that your physician has recommended, but the treatment or service has not yet been provided and the treatment or service is for non-urgent care for which the Plan does not require prior authorization is not a Claim under these procedures. In this circumstance, you may request a determination from the Trust Fund Office or Anthem Blue Cross regarding the Plan's coverage of the treatment or service. However, this will not be a guarantee of payment because such a request is not a Claim, and therefore will not be subject to the requirements and timelines described in this section.

Limitation on When a Lawsuit May Be Started

You may not start a lawsuit to obtain benefits until after you have requested a review and a final decision has been reached on review, or until the appropriate timeframe described above has elapsed since you filed a request for review and you have not received a final decision or notice that an extension will be necessary to reach a final decision.

Health Care Fraud

The Plan takes fraud very seriously. All claims are checked to be sure the patient is eligible and the treatment was received. The Trustees require a full refund of any benefit payment obtained by fraud, including interest and legal costs. Any incident involving fraud also may be referred to the authorities for criminal prosecution. Attempting to defraud a health plan is a crime under both federal and state laws, even if the fraud is detected and the Plan is not actually harmed. If you observe any activities by health care providers or others which might indicate fraud, please alert the Trust Fund Office in writing immediately. The Plan will investigate the matter and take whatever action is necessary. If you wish, your report will be confidential.

External Review of Claims Under the Direct Payment Plan

This external review process is intended to comply with the Affordable Care Act external review requirements as set forth in Interim Final Regulations implementing the Act and in Technical Release 2010-01.

If your appeal of a claim (whether pre-service, post-service or urgent care claim) is denied, you may request further review by an Independent Review Organization ("IRO") as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

NOTE that if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan, external review is not available.

External Review of Standard Claims

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

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

Preliminary Review

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

- You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;
- The Adverse Determination does not relate to your failure to meet the requirements for eligibility under the terms of the Plan;
- You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances); and
- You have provided all of the information and forms required to process an external review.

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

- If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).
- If your request is not complete, in which case the notice will describe the information or materials needed to make the request complete, and allow you to perfect the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review By Independent Review Organization

If the request is complete and eligible, the Plan will assign the request to an IRO. The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits.

Once the claim is assigned to an IRO, the following procedure will apply:

- The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).
- Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.
- If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with

applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

- The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
- The assigned IRO's decision notice will contain:
  * A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
  * The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;
  * References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
  * A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
  * A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
  * A statement that judicial review may be available to you; and
  * Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

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

Preliminary Review

Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review set forth above are met. The Plan will immediately notify you as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information described above.

Review By Independent Review Organization

Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review, at above section I.B. In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

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

After External Review

If the final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim.

If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed claim. If you are dissatisfied with the external review determination, you may seek judicial review as permitted under ERISA Section 502(a).

COORDINATION OF BENEFITS (COB) AND SUBROGATION

Benefits under the Automotive Industries Welfare Fund are designed to help meet the Allowable Expenses you and your Dependents actually incur. When Participants have coverage under more than one plan, the total benefits may exceed the actual expenses. Therefore, this Plan contains a provision in which benefits are coordinated with a Participant's other coverage.

If a Participant is entitled to benefits from another group plan for medical, prescription, vision, or dental expenses for which benefits are also due from this Fund, the benefits provided will be paid in accordance with the following provisions, not to exceed the amount of benefits which would have been paid in the absence of other group coverage or 100% of the Allowable Expenses actually incurred by the Participant.

Definitions

Allowable Expense. Any necessary, allowed expense for medical care and services, at least a portion of which is covered under at least one of the plans covering the person for whom claim is made. In no event shall an "Allowable Expense" exceed the lesser of:

* the normal charges billed for the expense by the Provider, or
* if the provider does not have a Preferred Provider Contract with either Plan, the highest Allowed Charge allowed by this Plan or the Plan(s) with which it is coordinating, or
* the contractual rate for such expense under a Preferred Provider Contract between provider and this Plan, or
* the contractual rate for such expense under a Preferred Provider Contract between the provider and the Plan with which this Plan is coordinating, or
* if the provider has a Preferred Provider Contract with both Plans, the lowest contract rate allowed by either Plan.

Benefits Credits. If, because of the coordination provision, this Plan does not pay its regular benefit, a record is kept of the reduction. This amount will be used to increase the patient's claim payments later in the same calendar year, to the extent there are allowable expenses that would otherwise not be fully paid by this Plan and the other Plans. Thus, on a later claim you may receive a greater benefit under this Plan than would normally be allowed.

Preferred Provider Contract. A contract under which a health care provider agrees to provide services to Participants at the rates specified in the contract. It does not have to be an exclusive arrangement.

Plan. Other than in reference to the Automotive Industries Welfare Fund, any program of coverage providing benefits except the following:

* Individual or family policies, or individual or family subscriber contracts.
* Medical benefits under Chapter 7 or Chapter 8 of Part III of Division 9 of the California Welfare and Institutions Code.
* Benefits payable under the California Crippled Children's Services program under Section 10020 of the California Welfare and Institutions Code or any other such similarly publicly funded program.
* Blanket insurance contracts issued pursuant to Section 10270.2(b) or (e) of the California Insurance Code which contain a nonduplication of benefits or excess policy provision.
* Medical payment benefits customarily included in the traditional automobile contract.

When a Plan provides benefits in the form of service rather than cash payment, the reasonable cash value of each service rendered shall be deemed to be both an Allowable Expense and a benefit paid.

Right to Receive and Release Necessary Information. To determine the applicability of Coordination of Benefits or any provision of similar purpose of any other plan, the Fund may, without consent of or notice to any person, release to or obtain from any organization or person which the Fund deems to be necessary for such purpose. In so acting, the Fund shall be free from any liability that might arise in relation to such action. Any person claiming benefits under this Plan shall furnish such information as may be necessary to implement Coordination of Benefits.

Facility of Payment. Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plan, this Plan shall have the right in its sole discretion to pay to any organization making such payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, this Plan shall be fully discharged from liability.

Right of Recovery. Whenever payments have been made by the Fund in excess of the maximum amount of payment necessary to satisfy the intent of Coordination of Benefits, the Fund shall have the right to recover payment to the extent of such excess.

Order of Benefit Determination

The rules for establishing the order of benefit determination are established in the following order:

1. The benefits of a plan which covers the claimant other than as a dependent shall be determined before the benefits of a plan which covers such person as a dependent.
2. For Dependents under this Plan:
   * The benefits of a plan which covers the person as a dependent of the parent whose birthday (month and day) occurs first in the year will pay benefits before the benefits of a plan which covers such person as a dependent of the parent whose birthday (month and day) occurs later in the year.

     EXCEPTION: The benefits of the plan using the gender rule will pay before the benefits of the plan using the birthday rule.
   * When the parents are separated or divorced and the parent with custody of the child has not remarried, the benefits of a plan which covers the child as a dependent of the parent with custody of the child will be determined before the benefits of the plan which covers the child as a dependent of the parent without custody.
   * When the parents are divorced and the parent with custody of the child has remarried, the benefits of a plan which covers the child as a dependent of the parent with custody shall be determined before the benefits of a plan which covers that child as a dependent of the step-parent, and the benefits of a plan which covers the child as a dependent of the step-parent will be determined before the benefits of a plan which covers that child as a dependent of the parent without custody.

   Notwithstanding paragraphs (b) and (c) above, if there is a court decree which would otherwise establish financial responsibility for the medical, dental or other health care expense with respect to the child, the benefits of a plan which covers the child as a dependent of the parent with such financial responsibility shall be determined before the benefits of any other plan which covers the child as a dependent child.

3. When rules (1) and (2) above do not establish an order of benefit determination, the benefits of a plan which has covered the claimant for the longer period of time shall be determined before the benefits of a plan which has covered such person for the shorter period of time.
4. Exceptions to the three rules above are:
   * the benefits of a plan which covers the claimant as an active employee or dependent of an active employee shall be determined before the benefits of the plan which covers such person as a retired or laid off employee or dependent of a retired or laid off employee.
   * the benefits of a plan which covers the claimant as an active employee or dependent of an active employee shall be determined before the benefits of the plan which covers such person as a COBRA beneficiary.
   * the benefits of a plan which covers the claimant as a natural or adopted dependent child shall be determined before the benefits of a plan which covers such person as a step-child, except as provided in (2) above.
5. If the Participant is an Active Employee or a Dependent of an Active Employee and is eligible for Medicare because he is entitled to disability payments from Social Security, Fund benefits will be provided without reduction to the extent required by Section 9319 of the Omnibus Budget Reconciliation Act of 1986.

Coordination with Medicare

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, dependent widow, or have chronic end-stage renal disease (ESRD). You should apply for Medicare at least three months prior to the date that you are eligible. Part A of Medicare is ordinarily free and you will be required to pay a monthly premium for Part B of Medicare.

Medicare benefits are secondary to benefits provided by this Plan for an Active Employee, and an Active Employee's eligible Spouse or other Dependent. If an Active Employee or their Spouse who are eligible for Medicare elects COBRA to extend Plan benefits, this action reverses the order so that Medicare will become the primary payer and the Plan becomes the secondary payer.

If benefits under this Plan are secondary to Medicare and a person entitled to Medicare benefits chooses not to enroll or fails to enroll, this Plan will not cover such person for those benefits which would have been available under Medicare.

It is IMPORTANT that the Plan Participant follow the Medicare rules and enrollment procedures and enroll in Medicare Part A and Part B when eligible. The Trust Fund cannot make these arrangements for any person.

Late enrollment for Medicare benefits may cause a delay in Medicare eligibility and require additional charges for coverages. Any questions regarding Medicare rules and enrollment requirements should be directed to an area Social Security office.

Acts of Third Parties

The Direct Pay Medical Plan A Benefits are subject to this provision.

If an eligible individual is injured through the act or omission of another party, Plan benefits are provided only on the following conditions:

1. Such eligible individual, or anyone receiving any Plan benefits as a result of the injury to the eligible individual, shall be required to pay to the Plan any and all proceeds in excess of the first $1,000 recovered collectively from all sources, including but not limited to proceeds designated as being punitive damages or for pain and suffering, received by way of judgment,

settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage) arising out of any claims for money or other damages by the eligible individual or his heirs, parents or legal guardians, or anyone else acting on his behalf, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. This obligation to pay the Plan applies whether the individual has been made whole or not. The assets so recovered shall be considered Plan assets and the recipient shall be under a fiduciary duty to pay them over to the Plan. In addition to any other remedy provided hereunder, the Plan shall be entitled to enforce this requirement by way of restitution or constructive trust.

2. Any eligible individual, or anyone acting on his behalf, who accepts payments from the Plan, or authorizes Plan payments to be made to anyone else, or on whose behalf any benefits are paid with respect to the eligible individual's injuries, agrees that a present assignment of the eligible individual's rights against such third party is automatically made to the extent of the payments made by the Plan.
3. These rules are automatic, but the Plan may require that any eligible individual or his representative sign an Agreement to Reimburse or Assignment of Recovery in such form or forms as the Plan may require. If an eligible individual, or his representative, refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan, the eligible individual shall not be eligible for Plan benefit payments related to the injury involved. This remedy is in addition to all other remedies the Plan may have.
4. If Plan benefits are paid on behalf of an eligible individual and upon recovery of any proceeds from or on behalf of the third party such benefits are not reimbursed to the Plan as set forth above, then the eligible individual will be ineligible for any future Plan benefit payment until the Plan has withheld an amount equal to the amount which has not been reimbursed. This remedy is in addition to all other remedies the Plan may have.
5. Any eligible individual on whose behalf the Plan pays benefits agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the eligible individual's own carrier for uninsured motorist's coverage.
6. An equitable lien by agreement shall exist in favor of the Plan upon all sums of money recovered by the eligible individual in excess of the first $1,000 recovered collectively from all sources as a result of the injuries to the eligible individual. The lien may, but is not required to, be filed with the third party's agents, or the court. The eligible individual, and those acting on his behalf, shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent. The eligible individual agrees to waive any defense based upon an inability of the Plan to trace the amounts recovered and agrees that the lien may be satisfied by any assets of the eligible individual.
7. If an eligible individual settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in the third party or its insurance carrier being relieved of any future liability for medical costs, then the eligible individual shall receive no further benefits from the Plan in connection with the medical condition forming the basis of the third party liability claim unless the Plan or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Plan.
8. In addition to all other remedies the Plan may have, the Plan shall be subrogated to the rights of the eligible individual against the responsible third party or its insurer.

SUMMARY PLAN DESCRIPTION INFORMATION

The Name and Type of Administration of the Plan

The Trust Fund Office will provide any Plan Participant or beneficiary, upon written request, information as to whether a particular employer is contributing to the Fund and, if so, that employer's address. The Trust Fund Office will provide any Plan Participant or beneficiary, upon written request, information as to whether a particular employer is contributing to the Fund and, if so, that employer's address.

The Plan is administered and maintained by the Joint Board of Trustees by contract with the firm of Associated Third Party Administrators. The Administrative Office of the Fund is located at:

Automotive Industries Welfare Fund
1640 South Loop Road
Alameda, California 94502
(510) 836-2484; (800) 635-3105

Direct Pay Medical Plan A Claims Address:

Automotive Industries Welfare Fund
PO Box 23263
Oakland, CA 94623-2363
(510) 836-2484; (800) 635-3105

The Plan does business under the name: Automotive Industries Welfare Fund.

Internal Revenue Service Plan Identification Number

The employer Identification Number (EIN) issued to the Board of Trustees is 94-1133245. The Plan Number is 501.

Name and Address of Person Designated as Agent for Service of Legal Process:

Saltzman & Johnson Law Corporation
44 Montgomery Street, Suite 2110
San Francisco, CA 94104

Service of legal process may be made upon a Trustee or Board of Trustees.

This Program is Maintained Pursuant to Various Collective Bargaining Agreements

Copies of the collective bargaining agreements are available for inspection at the Trust Fund Office during regular business hours, and upon written request, will be furnished by mail. A copy of any collective bargaining agreement which provides for contribution to the Fund will also be available for inspection within ten (10) calendar days after written request at your Local Union office or at any office of any contributing employer to which at least 50 Plan Participants report each day.

The Trust Fund Office will provide any Plan Participant or beneficiary, upon written request, information as to whether a particular employer is contributing to the Fund and, if so, that employer's address.

The Date of the End of the Plan Year

The date of the end of the Plan Year is December 31.

The Names and Addresses of the Trustees Are Listed Below:

Management Trustees

Bill Brunelli, Chairman
Central Collision Center
36849 San Pedro Drive
Fremont, CA 94536

James Canterbury
Horizon Lines
14627 SE 170th Place
Renton, WA 98058

Thomas A. Dillon
California Metal Trades Association
851 Burlway Road, Suite 216
Burlingame, CA 94010

Jon Rosselle
SSA Terminals, LLC
1717 Middle Harbor Road
Oakland, CA 94607-1205

Douglas Cornford
Western Management Alliance
7557 Gossamer Wind
Las Vegas, NV 89139

Labor Trustees

Jim Beno, Co-Chairman
IAM & AW District Lodge 190
7717 Oakport Blvd., Suite 1
Oakland, CA 94621

Thomas Brandon
Local Lodge No. 1596 & 1414
4210 Petaluma Blvd. North
Petaluma, CA 94952

Jose Santana
Local Lodge 1176
8400 Enterprise Way, Room 124
Oakland, CA 94621

Don Crosatto
Local Lodge 1546
10260 MacArthur Blvd.
Oakland, CA 94605

Mark Hollibush
Local Lodge No. 1173
1900 Bates Avenue, Suite H
Concord, CA 94520

Stephen Mack
Teamsters Automotive Local 853
2100 Merced Street
San Leandro, CA 94577

The Names and Addresses of all Health Care Issuers for the Medical Plan and Burial Benefit are:

Anthem Blue Cross Prudent Buyer
P.O. Box 60007
Los Angeles, CA 90060-0007

Contracts network, provides utilization review and case management for the Direct Pay Medical Plan A.

Managed Health Network (MHN)
2370 Kerner Boulevard
San Rafael, CA 94901

Provides insured Mental Health and Substance Abuse benefits

Kaiser Permanente Health Plan
California Division
1950 Franklin Street
Oakland, CA 94612

Provides pre-paid medical and prescription drug benefits.

Health Net
21600 Oxnard Street
Woodland Hills, CA 91367

Provides pre-paid medical benefits.

ING
6140 Stoneridge Mall Road, Suite 150
Pleasanton, CA 94588

Provides insured Burial Benefit and Life and AD&D Benefits.

Source of Financing of the Plan

The Plan is financed by employer contributions as a result of collective bargaining. The collective bargaining agreements provide that employers agree to make payment to the Automotive Industries Welfare Fund. Copies of collective bargaining agreements and participation agreements are available at participating local Unions or the Trust Fund Office.

If termination of the Automotive Industries Welfare Plan should ever occur, any remaining assets may (a) be utilized to provide and continue benefits as long as such assets permit, or (b) be transferred to a successor Plan providing similar benefits. Upon termination, the Trustees may revise benefits in any reasonable manner.

In no event will the termination of the Plan or the Trust result in a reversion of any assets to any contributing employer.

Benefits provided by the Automotive Industries Welfare Plan and described in this Summary Plan Description are

Indemnity Medical Plan, Prescription Drug benefits; Mental Health and Substance Abuse benefits, Burial Benefits, Indemnity and Scheduled Dental Plans, Vision benefits, and Life Insurance.

STATEMENT OF ERISA RIGHTS UNDER EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974

As a Participant in the Automotive Industries Welfare Plan you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Administrators shall be entitled to:

* Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and Union halls, all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed with the U.S. Department of Labor, such as Plan descriptions.
* Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
* Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.
* Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.
* Have a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan Administrators, ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Administrators 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 welfare benefit or exercising your rights under ERISA. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored in whole or in part, you may file suit in a state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. However, your right to sue may be limited if you have not exercised your right of appeal.

If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees if, for example, it finds your claim is frivolous.

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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.

COBRA CONTINUATION COVERAGE

The Consolidated Omnibus Budget Reconciliation Act of 1986 (COBRA), gives covered Employees and their covered Dependents the opportunity to temporarily continue their health care coverage at group rates up to 102 percent of the cost to the Plan when coverage under the Plan would otherwise end due to a Qualifying Event.

If you and your Dependents are covered under the Plan, you or your Dependents can continue coverage for a period of time if coverage ends for one of several reasons listed below (called Qualifying Events).

Qualifying Event	Employee	Dependents	Notification Requirements
Termination Employee's employment (for any reason except for gross misconduct)	18 months	18 months	Your employer will notify the Trust Fund Office
Reduction in Hours Employee's reduction in hours worked, including strikes or lockouts	18 months	18 months	Your employer will notify the Trust Fund Office
Death of Employee	N/A	36 months	Family member should notify the Trust Fund Office
Divorce or Legal Separation	N/A	36 months	Employee must advise the Trust Fund Office
Employee's Eligibility for Medicare Prior to Termination of Employment	18 months	Longer of 18 months from termination of employment or 36 months from Medicare eligibility	Employee must advise the Trust Fund Office
Dependent Child is No Longer Eligible for Coverage	N/A	36 months	Employee must advise the Trust Fund Office

WHEN THE PLAN MUST BE NOTIFIED OF A QUALIFYING EVENT

In order for a Dependent to be entitled to continue coverage, the Employee, or Dependent **must** notify the Plan of:

1. The divorce or legal separation from the Employee; or
2. The event under which a Dependent child loses Dependent status

within 60 days after the event occurs by sending a written notice to the Trust Fund Office. If the Plan does not receive written notice of any such event within that 60-day period, the Dependent will not be eligible for COBRA continuation coverage. This notification is also necessary so that the Trust Fund Office may provide you and/or Dependents with a Certificate of Creditable Coverage in the event COBRA Continuation Coverage is not elected.

Notice of Entitlement to COBRA Continuation Coverage

When your employment terminates or your hours are reduced so that you are no longer eligible for coverage under the Plan, or the Plan is notified on a timely basis that you died, divorced or were legally separated, or that a Dependent child lost Dependent status, you and/or your Dependent(s) will be notified that coverage has terminated and you and/or they have the right to elect to continue health care coverage. You and/or your Dependent(s) will have 60 days to apply for COBRA Continuation Coverage from the date notification is sent to you by the . If you and/or they do not apply within that time, you and/or they will have no further opportunity to continue your health care coverage.

COVERAGE PROVIDED WHEN COBRA CONTINUATION COVERAGE IS ELECTED

1. If you and/or your Dependent(s) elect COBRA Continuation Coverage, the Plan is required to provide medical/drug coverage that is identical to the current coverage that is provided for similarly situated Employees or family members. Also provided is life insurance for Employees electing COBRA on or after March 2, 2004. The life insurance level provided is $25,000. You have the option to pay additional premiums to also continue dental and vision coverage under the Plan. You will only be able to continue under COBRA those benefits you had as of your Qualifying Event.

2. If during the period of COBRA Continuation Coverage, you marry, have a newborn child, or have a child placed with you for adoption, that spouse of Dependent child may be enrolled for coverage for the balance of the period of COBRA Continuation Coverage on the same terms available to you. Enrollment must be requested no later than 30 days after the marriage, birth or placement for adoption.

   A child born or placed for adoption while you are on COBRA Continuation Coverage (but not a Spouse you marry while you are on COBRA Continuation Coverage) will have all the same COBRA rights as your Spouse or Dependent children who were covered by the Plan before the event that resulted in your loss of coverage. Otherwise, the same rules about Dependent status and qualifying changes in family status that apply to Employees will apply to those Dependents.

If, during the period of COBRA continuation coverage, the Plan's benefits change, the same changes will apply to you and/or your Dependent(s).

HOW TO ELECT COBRA CONTINUATION COVERAGE

The Trust Fund Office must be notified of your Qualifying Event in order for you or your surviving Spouse to elect COBRA Continuation Coverage.

* Your employer must notify the Trust Fund Office in the event of your termination of employment, reduction of your hours or your death.
* You (or your employer) should contact the Trust Fund Office within 60 days from the date that the qualifying event occurs, or the date that you would lose coverage under the Plan because of the Qualifying Event, whichever is later. See Notification Procedures below.

When the Trust Fund Office receives notice of the Qualifying Event, you will be mailed an election form, information about COBRA and the date on which your coverage will end. Under the law, you and/or your covered Dependents have 60 days from the later of the date:

* you would have lost coverage because of the qualifying event; or
* that the notice was issued to you by the Fund. Please note, it is your responsibility to keep the Fund informed in writing of all address changes;

to return the COBRA Election Form to the Trust Fund Office.

If you and/or any of your covered Dependents do not elect COBRA within this 60 day period you and/or your covered Dependents will not have any group health coverage from the Health and Welfare Plan after your coverage ends.

COBRA NOTIFICATION PROCEDURES

As an Employee or Qualified Beneficiary, you are responsible for providing the Trust Fund Office notice within **60 days** of the date you would have lost coverage for certain Qualifying Events:

* your divorce or legal separation from your Spouse;
* your Dependent's change in eligibility for coverage; and
* if you experience a second Qualifying Event after a Qualified Beneficiary has become entitled to COBRA with a maximum of 18 (or 29) months. This second Qualifying Event could include an Employee's death, divorce or legal separation or child losing Dependent status.

In addition to these Qualifying Events, there are two other situations where an Employee or Qualified Beneficiary is responsible for providing the Trust Fund Office with notice:

* When a Qualified Beneficiary becomes entitled to (i.e., enrolls in) Medicare while covered under COBRA continuation of coverage, notice must be sent no later than 60 days after Medicare entitlement.
* When the Social Security Administration determines that a Qualified Beneficiary is no longer disabled, notice must be sent no later than the end of the first 18 months of continuation coverage and no later than 30 days after the date of the determination by the Social Security Administration that you or your Dependent are no longer disabled.

You must make sure that the Trust Fund Office is notified of any of these five occurrences listed above. Failure to provide this notice within the timeframes described above may prevent you and/or your Dependents from obtaining or extending COBRA coverage.

Who Should Send the Notice

Notice may be provided by the covered Employee, Qualified Beneficiary with respect to the Qualifying Event, or any representative acting on behalf of the covered Employee or Qualified Beneficiary. Notice from one individual will satisfy the notice requirement for all related Qualified Beneficiaries affected by the same Qualifying Event. For example, if an Employee and his or her Spouse and Dependent Child are all covered by the Plan, and the Dependent Child ceases to become a Dependent under the Plan, a single notice sent by the Spouse would satisfy this requirement.

COST TO YOU FOR COBRA CONTINUATION COVERAGE

You and/or your covered Dependents will have to pay 102% of the full cost of the coverage during the COBRA Continuation period. However, any individual or family whose coverage is extended beyond 18 months because of entitlement to Social Security disability income benefits must pay 150% of the full cost of coverage during the 11-month extension of COBRA Continuation Coverage.

You may choose:

* **Core** coverage–medical, prescription drug (if provided to you as of the Qualifying Event); or
* **Core Plus** coverage–medical, prescription drug, dental, orthodontia, and vision (if provided to you as of the Qualifying Event); or
* **Core Plus Life** coverage–medical, prescription drug, burial, life insurance, dental, orthodontia, and vision (if provided to you as of the Qualifying Event).

Also provided is life insurance for Employees electing COBRA on or after March 2, 2004. The life insurance level provided is $25,000.

The Trust Fund Office will notify you of the cost of continuation coverage when it notifies you of your right to elect this coverage. You have a maximum of **45 days** from the date you mail your election form to the Trust Fund Office (as determined by postage cancellation) in which to submit your **first payment**. If you wait until the end of the election period, payment for each full month passed since the date active coverage terminated must be included with the first payment. If payment of the amount due is not received within 45 days of your election, COBRA Continuation Coverage will terminate.

The amount you and/or your covered Dependents must pay for your COBRA Continuation Coverage will be payable monthly. In order that your eligibility is correctly reflected in the Trust Fund records, **you should automatically send your check or money order to the Trust Fund Office before the first of each month**. No payment will be accepted which is more than 30 days after the first day of the coverage month. If payment of the amount due is not received by the end of the 30-day grace period, COBRA Continuation Coverage will terminate.

CONFIRMATION OF COVERAGE TO PROVIDERS

Federal rules require the Plan to inform your physician or other health care providers as to whether you have elected and/or paid for COBRA Continuation Coverage. This rule only applies where the physician or provider is requesting confirmation of coverage when you are eligible for, but have not yet elected, COBRA coverage, or you have elected COBRA coverage but have not yet paid for it.

The Trust Fund will not verify your eligibility during any period that you have not actually paid for COBRA coverage. Your eligibility will be retroactively reinstated upon receipt of your premium. No claims will be paid until your payment is received.

CHANGES TO MAXIMUM PERIOD OF COBRA CONTINUATION COVERAGE

Multiple Qualifying Events

If your COBRA Continuation Coverage is for a maximum period of 18 months, and during that period, another qualifying event takes place that would otherwise entitle a Spouse or Dependent Child to a 36-month period of COBRA Continuation Coverage, the 18-month period will be extended for that Spouse or Dependent Child. The total period of coverage for any Spouse or Dependent Child will never exceed 36 months from the date of the first qualifying event.

For example, if your employment terminated and you elected COBRA Continuation Coverage for 18 months for yourself and your Dependents, and you died during that 18-month period, the COBRA Continuation Coverage for your Dependents could be extended for the balance of 36 months from the date your Plan coverage ends.

However, if you become entitled to COBRA Continuation Coverage because of termination of employment or reduction in hours worked that occurred less than 18 months **after** the date you became entitled to Medicare, your Dependents would be entitled to a 36-month period of COBRA Continuation Coverage beginning on the date you became entitled to Medicare.

Entitlement to Social Security Disability Income Benefits

If you, or any of your covered Dependents are entitled to COBRA Continuation Coverage for an 18-month period, that period can be extended for all of your family participants covered by COBRA if any one of you is determined to be entitled to Social Security disability income benefits. The COBRA disability extension is provided for up to 11 additional months if all of the following conditions are satisfied:

1. the disability occurred on or before the start of COBRA continuation coverage, or within the first 60 days of COBRA continuation coverage; and
2. the disabled participant receives a determination of entitlement to Social Security disability income benefits from the Social Security Administration; and
3. the Plan is notified by you or the disabled participant that the determination was received:

    *no later than 60 days after it was received; and

    *before the 18-month COBRA continuation period ends.

This extended period of COBRA Continuation Coverage will end at the earlier of the end of 29 months from the date of the qualifying event or the date the disabled participant becomes entitled to Medicare or the last day of the month that occurs 30 days after Social Security has determined that you and/or your Dependent(s) are no longer disabled.

If you recover from your disability before the end of the initial 18 months of COBRA Continuation Coverage, you will not have the right to purchase extended coverage. You must notify the Trust Fund Office within 30 days of the date that you receive a final Social Security determination that you and/or your Dependent are no longer disabled or the date that the disabled person becomes entitled to Medicare.

TERMINATION OF COBRA CONTINUATION COVERAGE

COBRA Continuation Coverage may be terminated if:

1. The Fund no longer provides any Plan coverage to any of its similarly situated active Employees;
2. You do not pay the applicable premium for your COBRA Continuation Coverage on time;
3. You or your Dependent becomes entitled to Medicare; or
4. You or your Dependent becomes covered under another group health plan that does not limit or exclude you or your Dependent’s pre-existing conditions.
5. Your employer withdraws from the Trust Fund or Your former employer no longer provides for group health coverage through this Plan; however, the following exceptions apply to this rule:

    * If the employer goes out of business, continuation coverage will continue to be available for its former Employees subject to all other limitations on such coverage.

* If the Union is decertified as the bargaining representative of the Class 1 Employees of the employer, Cass 1 Employees on continuation coverage as of the month of decertification or before will be entitled to continue their continuation coverage, subject to all other limitations on such coverage. All other Employees of such employer shall have their continuation coverage terminated.

6. The date the Qualified Beneficiary's lifetime benefit maximum is exhausted on all benefits.

Notice of Early Termination of COBRA Continuation Coverage

If continuation coverage is terminated before the end of the maximum coverage period, the Trust Fund Office will send you a written notice as soon as practicable following the determination that continuation coverage will terminate. The notice will set out why continuation coverage will be terminated early, the date of termination, and your rights, if any, to alternative individual or group coverage.

Notice of Unavailability of COBRA Continuation Coverage

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

OTHER INFORMATION ABOUT COBRA CONTINUATION COVERAGE

If the coverage provided by the Plan is changed in any respect for active Employees, those changes will apply at the same time and in the same manner for everyone whose coverage is continued as required by COBRA. If any of those changes result in either an increase or decrease in the cost of coverage, that increase or decrease will apply to all individuals whose coverage is continued as required by COBRA as of the effective date of those changes.

CONTINUATION FOR DOMESTIC PARTNERS

NOTE: Domestic Partners and children of Domestic Partners are offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends (described in this chapter); however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary. This chapter describes in general how the Domestic Partner COBRA-like benefit will work. Contact the Fund Office with questions.

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

When your medical coverage ends, the Trust Fund Office will automatically provide you and/or your covered Dependents with a Certificate of Coverage that indicates the period of time you and/or they were covered under the Plan. If, within 63 days after your coverage under this Plan ends, you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, this certificate may be necessary to reduce any exclusion for pre-existing conditions that may apply to you and/or your covered Dependents in that group health plan or health insurance policy. The certificate will indicate if you had 18 months of creditable coverage prior to the date your coverage ended, and, if not, the period of time you and/or they were covered. The certificate will be sent to you (or to any of your covered Dependents) by first class mail shortly after coverage under this Plan ends. If you and any of your covered Dependents elect COBRA, another certificate will be sent to you by first class mail shortly after the Cobra Continuation Coverage ends for any reason **other than your return to active coverage**. If COBRA Continuation

Coverage is provided only to your covered Dependent(s), this Certificate will be sent to the Dependent(s). In addition, a certificate will be provided to you and/or any covered Dependent upon receipt of a written request for such a certificate if that request is received by the Trust Fund Office within two years after the later of the date your coverage under this Plan ended or the date COBRA Continuation Coverage ended.

CONVERSION PRIVILEGE FOR MEDICAL COVERAGE

At the end of the COBRA Continuation Coverage period, if you are enrolled in an HMO, you may convert your medical coverage to an individual plan without evidence of good health. The conversion plan may cost more and may provide fewer benefits than your HMO Plan through this Trust Fund. You must enroll within 30 days of the termination of your COBRA coverage. If you convert, the coverage is no longer provided through the Trust Fund. Contact your HMO for more information about this privilege.

HIPAA SPECIAL ENROLLMENT RIGHTS

This Plan complies with Special Enrollment Rights under the Health Insurance Portability and Accountability Act of 1996 because all eligible Employees and their eligible Dependents are covered for benefits when they meet the eligibility requirements. No Employee contribution is required for coverage.

THE TRADE ACT

The **Trade Adjustment Assistance Reform Act of 2002** (also called the Trade Act) creates a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired Employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (called eligible individuals).

- Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA.
- If you have questions about these new tax provisions call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282 (TTD/TTY: 1-866-626-4282). See also the information about the Trade Act at:
  www.doleta.gov/tradeact/2002act_index.cfm

EXTENSION OF MEDICAL EXPENSE BENEFITS FOR DISABLED EMPLOYEES OR DEPENDENTS

If your medical coverage ends because your employment terminates, and if on that date:

* you or your Dependent is Totally Disabled; and
* you or that Dependent is not otherwise covered by Medicare or by any other group or individual health insurance policy or health care plan;

benefits for the medical condition causing the Total Disability will be extended for up to 12 months, provided the disabled person continues to be Totally Disabled.

The extension applies only to the disabled person and only to the condition that causes the Total Disability. The terms and conditions of the Plan continue to apply.

If you or that covered Dependent are covered by any other group or individual health care insurance policy or health care plan or by Medicare, this extension of medical coverage will not apply.

Exceptions to Extensions. No payment shall be made under this extension of benefits:

* for any expense incurred for any child on account of pregnancy or complications of pregnancy;
* for any injury or sickness not related to the disabling condition; or
* for any expense incurred for supplies or services excluded by the General Direct Pay Medical Plan A Limitations.

This Extension is ***in lieu of COBRA*** Continuation of Coverage and is not available upon the termination of coverage under COBRA. Likewise, the termination of this extended coverage due to disability is not a COBRA Qualifying Event.

POST-COBRA COVERAGE UNDER AN HMO

The following provision applies **only** to Kaiser and Health Net enrollees.

California COBRA Law

If you are a COBRA participant enrolled in Kaiser or Health Net coverage, California law has a provision that affects the length of time you may continue coverage. This law only applies to Kaiser and Health Net coverage, not to any other benefits usually available under COBRA. If your qualifying event was low hours, termination of your employment, or retirement and you exhaust the 18 months of coverage normally available after such a qualifying event (or the 29 months available in the case of disability), you may continue your Kaiser or Health Net coverage an additional 18 months (or an additional 7 months in the case of a disability).

Note: All arrangements for additional months of coverage under the California COBRA law must be made directly with Kaiser or Health Net and not through the Trust Fund Office.

Check your Kaiser or Health Net Evidence of Coverage for more information on how to elect post-COBRA extended coverage under California law or enroll in a conversion plan. You can also call the HMO's Member Service departments.

HIPAA PRIVACY DISCLOSURES AND CERTIFICATION

Protected Health Information. For purposes of this section, the term "Protected Health Information" ("PHI") shall have the same meaning as in 45 CFR § 164.501. This section is administered by the Trustees in accordance with regulations adopted by the Department of Health and Human Services at 45 CFR Part 164.

Request, Use and Disclosure of PHI by Trustees. The Trustees are permitted to receive PHI from the Plan, and to use and/or disclose PHI only to the extent necessary to perform the following Plan Administrative functions:

- To make or obtain payment for care received by Eligible Individuals.
- To facilitate treatment which involves the provision, coordination or management of health care or related services.
- To conduct health care operations to facilitate the administration of the Plan, including enforcement of Plan liens, and as necessary to provide coverage and services to Eligible Individuals.
- In connection with judicial or administrative proceedings in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process.
- If legally required to do so by any federal, state or local law, or as permitted or required by law for law enforcement purposes.
- To review enrollment and eligibility information or claim appeals, solicit bids for services, modify, amend or terminate the Plan, or perform other Plan Administrative functions. The Board of Trustees may also receive summary health information for purposes of obtaining premium bids or setting or evaluating rates, or for evaluating, modifying or terminating benefits.
- For authorized activities by health oversight agencies, including audits, civil, administrative or criminal investigations, licensure or disciplinary action.
- To prevent or lessen a serious and imminent threat to an Eligible Individual's health or safety, or the health and safety of the public, provided such disclosure is consistent with applicable law and ethical standards of conduct.
- For specified government functions under 45 CFR Part 164.
- To the extent necessary to comply with laws related to workers' compensation or similar programs.

Trustee Certification

The Plan will only disclose PHI to a Trustee upon receipt of a certification that these procedures have been adopted and the Trustees, as Plan Sponsor, agree to the following:

- The Trustees will not use or disclose any PHI received from the Plan, except as permitted in these procedures or as required by law.
- The Trustees will ensure that any of their subcontractors or agents to whom they may provide PHI that was received from the Plan, agree to written contractual provisions that impose at least the same obligations to protect PHI as are imposed on the Trustees.

- The Trustees will not use or disclose PHI for employment-related actions and decisions or in connection with any other benefit or Employee Benefit Plan of the Trustees.
- The Trustees will report to the Plan any known impermissible or improper use or disclosure of PHI not authorized by these procedures of which they become aware.
- The Trustees will make their internal practices, books, and records relating to the use and disclosure of PHI received from the Plan available to the Department of Health and Human Services ("DHHS") or its designee for the purpose of determining the Plan's compliance with HIPAA.
- When the PHI is no longer needed for the purpose for which disclosure was made, the Trustees must, if feasible, return to the Plan or destroy all PHI that the Trustees received from or on behalf of the Plan. This includes all copies in any form, including any compilations derived from the PHI. If return or destruction is infeasible, the Trustees agree to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

Minimum Necessary Requests

The Trustees will use best efforts to request only the minimum necessary PHI to carry out the functions for which the information is requested.

Adequate Separation

The Trustees represent that adequate separation exists between the Plan and the Plan Sponsor so that PHI will be used only for Plan administration. Each Trustee will certify that he has no Employees, or other persons under his control that will have access to PHI.

Effective Mechanism for Resolving Issues of Noncompliance

Anyone who suspects an improper use or disclosure of PHI may report that occurrence to the Plan Privacy Official.

HIPAA Security

Effective April 21, 2005 in compliance with HIPAA Security regulations, the Plan Sponsor will:

- Implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity and availability of electronic PHI that it creates, receives, maintains or transmits on behalf of the Group Health Plan,
  Ensure that the adequate separation discussed above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI, and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

GENERAL DEFINITIONS

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

1. **With respect to a network provider** (PPO network Health Care or Dental Care provider/facility), the fee set forth in the agreement between the PPO network Health Care or Dental Care Provider/facility and the PPO network or the Plan; **or**
2. **With respect to a non-network provider**, allowed charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible medically necessary services or supplies performed by non-network providers. The Plan's allowed charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim; **or**
3. For an In-Network health care provider/facility whose network contract stipulates that they do not have to accept the network discount for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance or where this Plan may be a secondary payer, the allowed charge amount under this Plan is the discounted fee that would have been payable by the Plan had the claim been processed as an In-Network claim; **or**
4. The Health Care or Dental Care Provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible and Coinsurance. This is because the Plan covers only the "allowed charge" amount for health care services or supplies.

Any amount in excess of the "allowed charge" amount does not count toward the Plan's annual Out-of-Pocket Maximums. Participants are responsible for amounts that exceed "allowed charge" amounts by this Plan.

Birthing Center. An institution, which is not a Hospital, but a place, equipped to assist a woman in normal childbirth. It must be licensed by the state as a Birthing Center if the state has a license requirement. If the state does not have any license requirement, it must meet all the following tests:

* It is part of an office or clinic of a Physician, and has at least two birthing rooms;
* It has at least one Physician or one licensed Registered Nurse certified as a nurse midwife in attendance at all times;
* It has obstetrical equipment and supplies including, but not limited to, oxygen, suction, resuscitation and incubation equipment;
* It will accept a Participant as a patient only if her Physician's prognosis is that the pregnancy will result in normal childbirth;
* It has a written agreement with a licensed ambulance service for that service to provide immediate transportation of the Participant to a Hospital if an Emergency arises;

* It has a written agreement with a Hospital located within 20 minutes transport time from the Birthing Center and equipped for all obstetrical or surgical emergencies to provide emergency admission of the Participant if an Emergency arises.

Burial Benefit Claim. A Claim for Burial Benefits following the death of the Employee who is covered medical benefit under Medical Plan A .

Concurrent Claim. A Claim that is reconsidered, after an initial approval was made, and results in a reduction, termination or extension of a benefit. An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed at three days to determine if the full five days is appropriate. In this situation, a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.

Disability Claim. A claim that requires a finding of Total Disability as a condition of eligibility.

Emergency Medical Condition" is a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman of her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part. The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Employee. A person who is employed by an employer covered by a collective bargaining agreement or a subscription agreement, on whose behalf the employer is required to make contributions to the Plan and who satisfies the eligibility requirements of the Plan as specified in the *Eligibility Provisions* section of this booklet.

Experimental. A drug, device, medical treatment or procedure that:

* is under investigation, limited to research or restricted to use at centers which are capable of carrying out disciplined clinical efforts and scientific studies; or
* the drug, device, medical treatment or procedure, or the patient informed consent document utilized with it, was reviewed and approved by the treating facility's institutional review board or federal law requires such review or approval; or
* the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or
* reliable Evidence shows that the prevailing opinion among experts is that further studies or clinical trials are necessary to determine toxicity, safety or efficacy as compared with a standard means of treatment or diagnosis. Reliable evidence means ONLY:
    - reports and articles in peer reviewed authoritative medical and scientific literature; and/or
    - the written protocol(s) used by the treating facility or another facility studying substantially the same drug, device, medical treatment or procedure.

Home Health Care Agency. A licensed facility that meets all of the following requirements:

* It must primarily provide skilled nursing services and other therapeutic services under the supervision of Physicians and Registered Nurses;
* It must operate according to policies established by a professional group, including Physicians and Registered Nurses, which governs the services provided;

* It must maintain clinical records on all patients; and

* It must be licensed by the jurisdiction where it is located, operate according to the laws of that jurisdiction which pertain to agencies providing Home Health Care, and be certified as a Home Health Care Agency by Medicare.

Hospice or Hospice Agency. A facility or organization which administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care during the final stages of terminal illness and during bereavement. The facility or organization must be certified by the National Hospice Organization, Medicare, and local licensing organizations.

Hospital. An institution operated pursuant to law that meets the following requirements:

* It is equipped with permanent facilities for diagnosis, major surgery, and 24-hour continuous nursing service by registered professional nurses (R.N.) and 24-hour continuous supervision by a staff of physicians licensed to practice medicine (other than physicians whose license limits their practice to one or more specified fields), and it maintains a clinical record for each patient;

* It is primarily engaged in providing diagnostic and therapeutic facilities for medical and surgical care of injured and sick persons on a basis other than as a place for custodial care or rest, nursing home, a place for the aged or similar institution;

* For the purposes of the benefits provided for treatment of mental, nervous or emotional disorders or conditions, an institution that lacks permanent facilities for surgery will be considered a Hospital and an institution that is primarily a place for the care of persons with mental, nervous or emotional disorders or conditions will be considered a Hospital, provided that such institutions meet all the other requirements applied to Hospitals.

* It complies with all licensing and other legal requirements, and is recognized by the Secretary of Health, Education and Welfare of the United States pursuant to Medicare.

Illness. A non-occupational bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. Pregnancy of a covered Employee or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan. However, **infertility is not an Illness** for the purpose of coverage under this Plan.

Injury. Physical harm sustained as the direct result of a non-occupational accident, affected solely through external means, and all related symptoms and recurrent conditions resulting from the same accident.

Inpatient Preauthorization. The process where the Review Organization under contract to the Plan determines the Medical Necessity of a Participant's:

* elective non-emergency confinement to a Hospital (see "Pre-Service Claim" for childbirth exception), or

* elective non-emergency confinement to a Skilled Nursing Facility.

If you do not receive Inpatient Preauthorization when it is required, the benefit payable will be reduced by $250. If the Review Organization does not find the hospitalization Medically Necessary, no benefits will be paid.

If the confinement or services are found to be Medically Necessary, the Review Organization will determine the number of preauthorized days eligible for benefit coverage according to the terms of the Plan, prior to such elective non-emergency confinement or care actually occurring.

Large Case Management. For medically specific Illnesses or Injuries, or an Illness or Injury that is considered to be long-term or repetitive, the process whereby care is focused on the most appropriate plan of treatment.

Medically Necessary or Medical Necessity. Services and supplies if such service or supply is determined by the Plan to be:

* Appropriate for the symptoms, diagnosis or treatment of the Illness or Injury; and
* Provided for the diagnosis or direct care and treatment of the Illness or Injury, within standards of good medical practice within the organized medical community; and
* Not primarily for the convenience of the Participant, the Participant's Physician or another provider; and
* The most appropriate supply or level of service, which can safely be provided. For Hospital confinement, this means that acute care as an inpatient is necessary due to the kind of services the Participant is receiving or the severity of the Participant's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Medicare. The insurance program established by Title XVIII, United States Social Security Act of 1965, as originally enacted or as subsequently amended.

Out-of-Area Services. When a Participant does not have access to a PPO provider within 30 miles of their home or work.

Out-of-Pocket Maximum. A Plan maximum of Out-of-Pocket expenses that an eligible Participant and eligible family must incur in a calendar year, after satisfaction of the Plan deductible, before the Plan pays 100% of those expenses. These applicable expenses include the following:

* Covered PPO provider expenses;
* Allowable Expenses for ambulance and emergency services; and
* Covered out-of-area services.

Outpatient Surgical Center. A state licensed facility, which is not a Hospital, but meets all of the following requirements:

* It provides surgical facilities for ambulatory, outpatient surgical care, providing continuous Physician and Registered Nursing services while patients are in the facility;
* It is equipped with permanent surgery facilities and is staffed by Registered Nurses, Physicians and anesthetists licensed to practice medicine; and
* It is a place other than a Physician's office, and it does not provide accommodations for patients to stay overnight.

Participant. Any person eligible for benefits under the Plan, whether as an Employee or Eligible Dependent.

Physician. Any of the following individuals who is licensed and practices within the scope of the license. A Physician must not be a Relative of or have the same legal address as the Participant.

* A Doctor of Medicine (M.D.).
* A Doctor of Osteopathy (D.O.).
* A Dentist (D.D.S. or D.M.D.).
* A pathologist

* A radiologist.
* A professional anesthetist.
* A psychologist (Ph.D.).
* A registered physical or speech therapist, if referred by a Physician.
* A chiropractor (D.C.).
* A podiatrist (D.P.M.).
* An optometrist (O.D.).
* A Registered Nurse midwife; a Registered Nurse practitioner.
* A Physician's assistant, if under the supervision of a Physician (payable in accordance with Medicare guidelines).

Plan. Except as noted and defined otherwise, "Plan" is the program established by the Trustees of the Automotive Industries Welfare Fund to provide Medical, Dental, Prescription Drug, Vision and other related benefits to eligible persons.

Post-Service Claim. A Claim not classified as a Pre-Service, Urgent Care or Concurrent Claim. Usually these will be claims submitted for payment after health services and treatment have been obtained.

PPO Provider. For mental health and chemical dependency benefits: a Hospital, Physician, Allied Health Professional or other covered facility that provides care at negotiated rates due to an arrangement with United Behavioral Health.

For other medical benefits: a Hospital, Physician, Allied Health Professional or other covered facility that provides care at negotiated rates due to an arrangement with Anthem Blue Cross Prudent Buyer/Blue Card.

The term "Non-PPO Provider" means a provider that does not have such an arrangement.

Pregnancy. All pregnancies, childbirth, and voluntary termination of pregnancy for an Employee or Spouse only. Complications of Pregnancy will be considered as any other illness. Charges related to pregnancy or complications of pregnancy of Dependent Children are not covered.

The term "Complications of Pregnancy" means physical effects suffered which have been directly caused by the pregnancy, but which are not considered from a medical viewpoint the effects of a normal pregnancy. "Complications of Pregnancy" shall include, but not be limited to, conditions such as acute nephritis, nephrosis, cardiac compensation, missed abortion, ectopic pregnancy which terminated, Caesarian section, spontaneous terminations of pregnancy which occur during a period of gestation in which a viable birth is not possible, and similar medically diagnosed conditions.

Pre-Service Claim. A Claim for a benefit for which the Plan requires approval of the benefit (in whole or in part) from Anthem Blue Cross (or United Behavioral Health for mental health and substance abuse benefits) before medical care is obtained in order to receive the maximum benefits provided by the Plan. Under the terms of this Plan, prior approval of services by Anthem Blue Cross is required for the following benefits:

* Hospital services (except emergencies, hospitalization for childbirth up to 48 hours following normal delivery, or 96 hours following a caesarean section, or when the Plan is the secondary payer);
* Ambulatory Surgical Facility treatment
* Home health care and hospice care;

* Skilled Nursing Facility admissions;
* Large Case Management, including organ transplants

Rehabilitative Therapy. Therapy to restore physical function lost due to illness or injury, including physical therapy, speech therapy and occupational therapy.

Review Organization. A third party retained by the Plan to conduct Inpatient Preauthorization, Utilization Review, and Large Case Management under the Plan. Anthem Blue Cross Prudent Buyer is the Review Organization.

Registered Nurse (R.N.). A person licensed as a Registered Nurse under the appropriate laws who is not a Relative to the Participant and does not have the same legal address as the person receiving the nursing care.

Relative. By blood or marriage, the Participant's Spouse, parents, children, siblings, or anyone residing in the same household as the Participant.

Skilled Nursing Facility. An institution that meets all the following tests:

* Primarily provides skilled nursing care to registered inpatients under 24 hour-a-day supervision of a Physician or Registered Nurse;
* Has available at all times a Physician who is a staff member of a Hospital;
* Has on duty 24 hours a day a Registered Nurse, licensed vocational nurse, or licensed practical nurse, and has on duty at least eight hours a day a Registered Nurse;
* Maintains a daily medical record for each patient;
* Complies with all licensing and other legal requirements and is recognized as an "extended care facility" pursuant to Title XVIII of the Social Security Amendments of 1965 and as amended; and
* Is not, except incidentally, a place of rest, a place for custodial care for the aged, for drug addicts, for alcoholics, or similar institution.

Total Disability or **Totally Disabled**. For an Employee, this means that, as a result of Injury or Illness, the Employee is unable to engage in any and every duty pertaining to his customary occupation and is performing no work of any kind for pay or profit.

Note that life insurance definition is any occupation for which the individual is qualified by reason of education, training or experience

For a Dependent, this means, as a result of Injury or Illness, a Dependent is unable to engage in substantially all regular and customary activities usual for a person of similar age and family status.

Trust Agreement means The Trust Agreement establishing the Automotive Industries Welfare Fund and any modification, amendment, extension or renewal thereof.

Union. District Lodge No. 190, Automotive Machinists Lodge 1546, Teamsters Local 853, Automotive Painters Local 1176, East Bay Automotive Council on Behalf of Its Affiliates, Northern California Automotive Machinists Council on Behalf of Its Affiliates, and other participating Unions.

Urgent Care Center. A facility that meets professionally recognized standards and all of the following:

* While it may provide routine medical management, it mainly provides urgent or emergency medical treatment for acute conditions.
* It does not provide accommodations for overnight stays.
* It is open to receive patients each day of the calendar year.
* It has on duty at all times a Physician trained in emergency medicine, and nurses and other supporting personnel who are specially trained in emergency care.
* It has x-ray and laboratory diagnostic facilities and emergency equipment, trays, and supplies for use in life-threatening events.
* It has a written agreement with a local acute care Hospital for the immediate transfer of patients who require greater care than can be furnished at the facility; written guidelines for stabilizing and transporting such patients; and direct communication channels with the acute care Hospitals that are immediate and reliable.
* It complies with all licensing and other legal requirements.

Urgent Care Claim. Any claim for medical care or treatment with respect to which the application of the time periods for making Pre-Service Claim determinations:

* could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
* in the opinion of a physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

Alternatively, any Claim that a physician with knowledge of your medical condition determines is an Urgent Care Claim within the meaning described above shall be treated as an Urgent Care Claim.

KAISER SUMMARY OF BENEFITS

Following is a brief summary of the benefits available if you enroll in the Kaiser HMO. Please note if there is a discrepancy between the benefits on this Summary and your Evidence of Coverage from the HMO, **the Evidence of Coverage will prevail.**

BENEFIT	PLAN A - KAISER PERMANENTE
Office Visit	100% after $20/visit
Percentage Payable	100% after applicable copay
Calendar Year Deductible	None
Out of Pocket Max	$1,500 Individual/$3,000 Family
Lifetime Maximum	None
Inpatient Hospital	100%
Outpatient Surgery	100% after $10 copay per procedure
Emergency Room	100% after $10 copay (waived if admitted)
Skilled Nursing Facility Care	100% up to 100 days per benefit period
Home Health Care	100% up to 100 visits per calendar year
Hospice Care	100%
Diagnostic X-Ray and Lab	100%
Physical Therapy	100% after $10/visit
Preventive Care	100%
Alcohol/Substance Abuse	Inpatient detox: 100% Outpatient: $20 individual visit / $5 group visit This coverage is also provided by MHN Coverage at 90%. $250 calendar year deductible for inpatient care up to 30 days per calendar year. All treatment must be preauthorized. Outpatient: 2 Treatment Programs per calendar year
Mental Health	This coverage is provided by Kaiser
Inpatient	100%; unlimited on days
Outpatient	100% after $20 per individual visit or $10 per group visit; unlimited on days
Member Assistance Program (MAP) Employee only	This coverage is provided by MHN 1-3 sessions. $0 copay
Outpatient Prescription Drug	Coverage is provided through Kaiser. **Retail Pharmacy**: Generic: $15 copay Brand Name: $30 copay **Mail Order:** Generic: $30 copay Brand Name: $60 copay for 100 days supply
Chiropractic Care	Not Covered

HEALTH NET SUMMARY OF BENEFITS

Following is a brief summary of the benefits available if you enroll in the Health Net HMO. Please note if there is a discrepancy between the benefits on this summary and your Evidence of Coverage from the HMO, **the Evidence of Coverage will prevail.**

BENEFIT	HEALTH NET
Office Visit	100% after $20/visit for Primary Care Physician, $40 for Specialist
Percentage Payable	100% after applicable copay
Calendar Year Deductible	None
Out of Pocket Max	$4,500 Individual/$9,000 Family
Lifetime Maximum	None
Inpatient Hospital	80% (subject to copayment limit)
Outpatient Surgery	80% (subject to copayment limit)
Emergency Room	100% after $100 Copay (waived if admitted)
Skilled Nursing Facility Care	80% up to 100 consecutive calendar days from first treatment per disability
Home Health Care	100% after $10/visit, 100 visits/calendar year.
Hospice Care	100%
Diagnostic X-Ray and Lab	100% except specialized radiological procedures (CT, SPECT, PET, MUGA and MRI) 100% after $200/procedure.
Physical Therapy	100%
Preventive Care	Preventive care that is required to be covered under Health Care Reform will be payable at 100%
Preventive Care for Children	100% after $20/visit; up to age 2
Alcohol and Substance Abuse	This coverage is provided by MHN MHN Provider: coverage of 100%; No deductible Non-MHN Provider: $250 calendar year deductible. Coverage of 50% of allowed charges
Mental Health	This coverage is provided by MHN
Inpatient	90% coverage up to 30 days per calendar year. In-Network only.
Outpatient	MHN Provider: $5 copay up to 50 visits per calendar year.
	Non-MHN Provider: 50% of allowed charges and 50 visits per calendar year.
Member Assistance Program (MAP) Employee only	This coverage is provided by MHN 1-3 sessions. $0 copay

Outpatient Prescription Drug	Coverage through Prescription Solutions. **Retail Pharmacy**: 20% plus $5 (for generic or brand-name regardless of whether on the formulary). Maximum copay of $100 per brand name prescription if the drug is unavailable as generic and unavailable through mail order. Also, $100 maximum co-payment for injectables **Mail Order:** Formulary generic drugs: 100% after $40 per prescription Brand-name drugs: 100% after $60, regardless of whether the drug is on the formulary.
Chiropractic Care	Not Covered

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