AUTOMOTIVE INDUSTRIES WELFARE FUND

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

EFFECTIVE SEPTEMBER 1, 2019

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 C** benefits. This document is effective September 1, 2019, and replaces all other documents previously provided to you by the Trust Fund Office.

- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment. Receipt of this document does not guarantee eligibility for Plan benefits.
- No individual shall have accrued or vested rights to benefits under this Plan. A vested right refers to a benefit that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested.

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, service of legal process may be made upon Kaiser Permanente 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 Fund. Si usted tenga dificultad a entendar algo en este librito, contacto Health Services & Benefit Administrators a 4160 Dublin Blvd., Suite 400 Dublin, CA 94568. Horas de oficina son de las 8:300 A.M. hasta 5:00 P.M., Lunes por Viernes. Tambien puede llamar la oficina del administrador a (800) 636-3105 para asistencia.

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

The website contains information regarding the Welfare Fund 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 Employees 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 Fund*** website at www.aitrustfunds.org.

The website contains information regarding the Welfare Fund 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, and certain IRS reporting rules, you must promptly furnish to the Plan Administrator the Social Security number of all Plan Participants, 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. If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE.

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:

Direct Pay Medical Plan C Benefits	Phone Number	Web Site
Trust Fund Office Claims, Billing and Eligibility	(800) 635-3105	www.aitrustfunds.org
PPO Provider Network Anthem Blue Cross Prudent Buyer/Blue Card For providers within California For providers in other states	(800) 810-BLUE	www.anthem.com
Anthem Blue Cross Inpatient Preauthorization & Utilization Review **Anthem Benefit Advisor (ABA)**	(800) 274-7767 (844) 437-0488	www.anthem.com
HMO Plan Kaiser Permanente Group No. 57	(800) 464-4000	www.kaiserpermanente.org
Prescription Drug Information (for all Direct Pay Plan C Enrollees) Optum Rx Mail Order drugs Specialty Drugs	1-855-427-4682 1-877-839-7045	www.optumrx.com
Managed Health Network Employee Assistance Program (EAP) for Employees only	(800) 748-2559	www.members.mhn.com register with access code: aiwfmap
Dental Plan Options		
Delta Dental Plan	(866) 499-3001	www.deltadentalins.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
Hearing Aid Vendor HearUSA	(800) 635-3105	https://www.aitrustfunds.org
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

Direct Pay Medical Plan C Benefits	Phone Number	Web Site
Burial Benefit	(800) 635-3105	www.aitrustfunds.org
Life Insurance	(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.

The Fund provides health and welfare benefits including Medical, Prescription Drug, Dental, Orthodontia, Vision, Disability, Burial, and Life Insurance Benefits. However, you are only entitled to those benefits that have been negotiated, between your employer and the Union. **To determine which benefits you are eligible for, you should refer to the collective bargaining agreement**.

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 C 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: A new Employee who lives 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; and
- 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.

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 proof of prior 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.

Exception: A new Employee may enroll in the Delta Dental PPO Plan rather than one of the pre-paid dental options if prior to enrolling in the Plan:

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

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 after your first 12 months of coverage (remember, newly hired Employees are **REQUIRED** to enroll in the Direct Pay Medical/Prescription Drug Plan C for the first 12 months they are eligible), 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 Kaiser or Pre-paid Dental Plan

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

* the Direct Pay Medical Plan C; and
* an Indemnity Dental Plan—the Basic Delta Dental Plan administered by Delta Dental.

If you are considering enrolling in the Kaiser 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*** issued by Kaiser or Pre-paid Dental Plan.

If you complete and return the **enrollment form** and select Kaiser, 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 Kaiser or the Pre-paid Dental Plan, you will receive your ***Evidence of Coverage*** for Kaiser or the 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. Use your Kaiser 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. <u>If you enroll in Kaiser, you will use your ID card to obtain prescriptions drugs at a Kaiser facility</u>.

If you enroll in Direct Pay Plan C, your prescription drug benefits are available through Prescription Solutions pharmacy under the Direct Pay Plan C. 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 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. Voya will issue a 1099 with your payment for tax purposes.

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 Kaiser 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 or 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.

Opt-Out of Coverage

You are only eligible for benefits which have been negotiated between your employer and the union. You may opt-out of all negotiated benefits or some of them. Should you wish to opt-out, the following are your options if your employer has negotiated with your union:

- ***Option 1***: opt-out all benefits.
- ***Option 2:*** opt-out medical and prescription drug; retain vision, dental, orthodontic, life and disability benefits.
- ***Option 3:*** opt-out vision, dental, orthodontic, life and disability; retain medical and prescription drug.
- Any member eligible for dental benefits may notify the Fund Office if they do not want to receive those benefits.

You may opt back into coverage due to a HIPAA special enrollment event (please see page 7). This includes certain events such as birth of a child and loss of other Group Health Coverage, if the Trust Fund Office is notified of the change within 31 days. Coverage under an opt-in request will begin the first of the month following 31 days after receipt of a completed opt-in form. Note that coverage for a newborn or newly adopted child must be retroactive to the date of birth or placement for adoption if the request is made within 31 days.

When Coverage Begins

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 same-sex or opposite-sex Domestic Partner if there is a registered domestic partnership with a governmental body pursuant to state or local law authorizing such registration.

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 who is in full-time military service.

If you do not enroll your Dependent(s) when you first become eligible for coverage, you may do so at a later time. In this case, coverage will begin the first of the following month upon receipt of enrollment and required documentation.

Exception for newly acquired dependents: you will need to submit the form requesting enrollment of a newborn child within 31-days of the date of birth. Provided you submit the enrollment form within 31 days, you will then have an additional 60 days (counted from the end of the 31-day period) to provide your child's birth certificate. If the birth certificate is not provided within the 91-day period, coverage for the newborn will terminate and any future coverage will be effective on the first date of the month following the month that the Fund Office receives the enrollment form and birth certificate.

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.

HIPAA Special Enrollment Rights

This section applies to Participants who choose to "opt-out" of (or choose not to have medical coverage. See page 4 for a description of the opt-out options. For other Participants, 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.

When you enroll, you may be allowed to "opt-out" of (or choose not to have) medical coverage if your Employer negotiated to allow the opt-out as part of contract negotiation. As you know, you are already able to opt-out of the self-funded dental benefits if you do not want these benefits. Following is a description of the times that you will be able to re-enroll in the plan.

- If you are not enrolled for coverage under this Plan and acquire a Spouse by marriage, or acquire any Dependent Child(ren) by birth, adoption or placement for adoption or marriage, you may request enrollment for yourself and/or your new Spouse, Domestic Partner and/or any Dependent Child(ren) no later than 31 days after the date of marriage, birth, adoption or placement for adoption.

  Provided you submit the enrollment form within 31 days, you will then have an additional 60 days (counted from the end of the 31-day period) to provide your child's birth certificate. If the birth certificate is not provided within the 91-day period, coverage for the newborn will terminate and any future coverage will be effective on the first date of the month following the month that the Fund Office receives the enrollment form and birth certificate.

- **Loss Of Other Coverage:** If, you did not request enrollment under this Plan for yourself, your Spouse/Domestic Partner and/or any Dependent Child(ren) within **31 days** after the date on which coverage under the Plan was previously offered because you or they had coverage under another group health plan or health insurance policy (including COBRA Continuation Coverage, certain types of individual health insurance, Medicare or other public program) **and** you, your Spouse and/or any Dependent Child(ren) **lose coverage** under that other plan or health insurance policy; you may request enrollment for yourself and/or your Dependents within **31 days** after the termination of their coverage under that other group health plan or health insurance policy **if** that other coverage terminated because of:
  - loss of eligibility for that coverage including loss resulting from legal separation, divorce, death, voluntary or involuntary termination of employment or reduction in hours (but does not include loss due to failure of employee to pay premiums on a timely basis or termination of the other coverage for cause); or
  - termination of employer contributions toward that other coverage (an employer's reduction but not cessation of contributions does not trigger a special enrollment right); or

- the health insurance that was provided under COBRA Continuation Coverage, and such COBRA coverage was "exhausted;" or
- moving out of an HMO service area if HMO coverage terminated for that reason and, for group coverage, no other option is available under the other plan; or
- the other plan ceasing to offer coverage to a group of similarly situated individuals; or
- the loss of dependent status under the other plan's terms; or
- the termination of a benefit package option under the other plan, unless substitute coverage offered.

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

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

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

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 at least 3 months and up to 12 months, depending on the terms of the collective bargaining agreement, provided the Totally Disabled person continues to be Totally Disabled.

The extension applies only to the Totally 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 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 C 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.

4. **Contract Employee (Class 1 Employees):** If a Class 1 Employee becomes Totally 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, or up to twelve months based on the terms of the collective bargaining agreement. Thereafter, the Class 1 Employee may extend his coverage only in accordance with COBRA.

   Class 1 employees entitled to the CTA extension of benefits for disability are entitled to eight months of additional benefits following the last month of employer contributions in the paragraph above.

5. **Non-Contract Employees (Class 2 Employees):** If a Class 2 Employee becomes Totally 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 this benefit. 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.

Family and/or Medical Leave (FMLA)

A regular Employee eligible for leave under the Family Medical Leave Act who takes such leave from covered employment shall be covered as if actively employed. The Contributing Employer owes a Contribution for all months of such leave if the Regular Employee would have had a Contribution made on his or her behalf but for the FMLA leave. Eligibility under FMLA must be exhausted prior to the implementation of any disability extension as noted above or any other approved leave of absence. The Contributing Employer is responsible for notifying the Fund's Administrative Office of Regular Employees who are eligible for FMLA.

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

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 on the day the Employee begins active employment with a Contributing Employer. 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.

Direct Pay Medical Plan C

Medical Plan Options

Depending on where you live, how long you have been eligible, and whether you are a Class 1 or Class 2 Employee, you may have a choice between receiving your medical benefits from the Indemnity Medical Plan C described in this booklet or from Kaiser. 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 the Kaiser 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 C Enrollment and Change Form** is received by the Trust Fund Office.

Your Options

New Employees must enroll in the Direct Pay Medical Plan C option for the first 12 months after they become eligible. After the initial 12 months, Employees who live in California have the option to disenroll from Direct Pay Medical Plan C and enroll in the Kaiser Permanente HMO. The HMO Plan is not available outside of California.

Exception: A new Employee who lives 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; and
- They were covered by Kaiser in the preceding 12 months; and
- They were covered under that Kaiser Plan for at least 12 months.

If your Collective Bargaining Agreement (CBA) and/or Subscriber Agreement allows you to do so, a Participant may opt-out of:

- Medical/Prescription Drug benefits; and/or
- Ancillary benefits (including dental, orthodontics, Life/AD&D, Disability and Vision).

If you would like to drop your Spouses and/or Dependents from coverage, contact the Trust Fund Office for an enrollment change form. Your Spouse must provide written concurrence to be dropped from coverage.

Contact the Trust Fund Office for enrollment forms.

Important Note to Kaiser Enrollees

If you are enrolled in Kaiser, you must refer to the ***Evidence of Coverage*** document provided by Kaiser 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 C Works

(These benefits do not apply to Kaiser Plan Participants)

This is a ***Comprehensive Indemnity Medical Plan*** under which you and the Plan share the cost of ***Allowed Charges:*** Each calendar year each participant must pay the first $1,000 ($2,000 Family)

of Allowed Charges, which is known as the ***Deductible.*** Additional Allowed Charges 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 $1,000 per person, or $2,000 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 Allowed Charge; or
- Charges not covered by the Plan.

Percentage Payable

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

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

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

LiveHealth Online Services

Members can now use their smart phone, tablet or computer to have a live video visit with a board certified doctor affiliated with the Anthem Blue Cross LiveHealth Online Services to discuss non-emergency health issues (including mental health and substance abuse issues) from home, work or wherever they happen to be as long as they have Internet access. This online care service, LiveHealth Online, offers a secure means of reaching board-certified, primary care doctors (or therapist or psychologist) on demand, especially when plan participants find it inconvenient to leave work or home and go to a doctor's office. Online care, for non-urgent medical conditions, is more convenient and affordable than a visit to the emergency room or an urgent care clinic. Patients use online care typically to communicate with a doctor about colds, aches, sore throats, allergies, infections as well as wellness and nutrition advice.

Members can access LiveHealth Online either by going to the website www.livehealthonline.com from a computer with a webcam and internet access *or* by downloading LiveHealth Online mobile app to their iOS or Android smartphone or tablet. **You will have to pay a $20 copay (deductible waived) when you use this service.**

TO ACCESS THIS PROGRAM:

1. Log on to **livehealthonline.com**.
2. Select **Sign Up** in the top right corner of the screen.
3. Complete the form to create your account and select **Finish**.
4. Review the physician profiles to select the one that's right for you and begin your consultation.

Medical Out-of-Pocket Maximum – for Contract Providers Only

If you use PPO Providers, once the amount you have paid Out-of-Pocket during a year reaches $2,000 per person ($4,000 family), the Plan will pay 100% of the Allowed Charges for most PPO covered services for the rest of that calendar year. Your Out-of-Pocket Limit will accumulate your payments for medical deductibles, coinsurance, and copays for services received from **PPO Providers**.

The Out-of-Pocket Limit is accumulated on a calendar year basis. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are received by the Plan. The annual Out-of-Pocket Limit is as follows:

Annual Out-of-Pocket Maximum	PPO Provider	Non-PPO Provider
Per Person	$2,000	None
Maximum per family	$4,000	None

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

- Premiums,
- Expenses for services or supplies that are not covered by the Plan,
- Charges in excess of the Allowed Charge determined by the Plan which includes balance billed amounts for Non-PPO providers,
- Penalties for failure to obtain preauthorization,
- Expenses for the use of Non-PPO providers (except for certain limited situations),
- Outpatient prescription drug expenses (there is a separate Out-of-Pocket limit on In-Network prescription drugs).
- Dental or vision services.

There are a few situations when your payments for services received from Non-PPO Providers will also accumulate towards the Out-of-Pocket Limit. These situations are as follows:

- Expenses paid when access to a PPO Provider is not within 30 miles of the Participant's home or work. Services received from a Non-PPO provider that could have been performed at a PPO provider located closer to the Participant will not accumulate towards the PPO Out-of-Pocket Limit;
- Expenses paid when a PPO Provider is not reasonably available;
- Expenses paid when treatment is for an Emergency Medical Condition rendered at a Non-PPO facility; or

- Expenses paid for services of a Non-PPO anesthesiologist or other Non-PPO specialist service requested by an attending PPO physician if services are performed at a PPO Hospital.

Other than the expenses listed above, there is no Out-of-Pocket Limit on payments you make for Non-PPO Provider services. This means that if you use Non-PPO providers, the amount that you may be responsible for is unlimited.

Prescription Drug Out-of-Pocket Maximum

In addition to the above limits, the Fund has a separate Out-of-Pocket Limit for outpatient In-Network prescription drug. Please see the prescription drug chapter beginning on page 39 for a complete description of this Out-of-Pocket Limit.

PPO Providers

The Fund has contracted with a Preferred Provider Organization (PPO) to provide a network of Hospitals, Physicians, outpatient 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 $2,000/$4,000 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 Allowed Charges 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 Allowed Charges 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.
- Expenses paid for services of a Non-PPO anesthesiologist or other Non-PPO specialist service requested by an attending PPO physician if services are performed at a PPO Hospital.

Caution Regarding Use of Non-PPO Doctors and Hospitals

Except as noted above, the Plan will pay the applicable percentage of Allowed Charges incurred by a Participant for non-PPO Providers. The percentage payable is 65% of Allowed Charges. Non-PPO expenses do not apply towards the 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 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 Allowed Charges.

Exception for Special Circumstances: 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 Allowed Charge provided that services are performed at a PPO Hospital. Allowed Charges that qualify under this Special Circumstances Exception will accrue toward the Plan's Out-of-Pocket maximum.

Non-PPO Specialty Providers

Anthem has an expansive network of PPO providers including a number of PPO specialists in each field. This means that if you receive treatment from a Non-PPO specialty provider, any covered services may be reimbursed at the Non-PPO level.

To find out if a provider is in the network, either ask the provider's office, contact the Fund Office or visit the Anthem Blue Cross website www.anthem.com/ca. If you live outside of California, you can find Blue Card providers online at www.bluecares.com, or you can call (800) 810-2583. (Note: outside of California, PPO Providers are called "PPO Providers" or "Blue Card Providers.")

Non-PPO Facilities

You may experience an increase in out-of-pocket costs if you use a Non-PPO facility because you may be billed for the difference between what the Fund pays and what the provider is charging (known as "Balance Billing"), in addition to your normal coinsurance. When you receive treatment from a PPO provider, you pay only your copay and/or percentage of the negotiated fee. The provider cannot charge you more than this PPO rate.

USE PPO PROVIDERS TO SAVE MONEY

When you need care, you can save money by seeing a provider in the network. And the cost savings can be substantial, even thousands of dollars, depending on the level of medical care needed. This is because Anthem contracts with doctors, hospitals, labs and other providers (called network providers) who agree to accept a certain price for the type of care they provide. This means they can't ask for more than this amount.

ALWAYS ASK IF A PROVIDER IS IN NETWORK

It's up to you to make sure you use network hospitals, facilities and doctors. If your doctor refers you to another provider, always ask if that provider is in the network. This includes when you have to stay in the hospital. It's important to ask the hospital staff if all the "facility-based providers" (such as radiologists, anesthesiologists, pathologists and neonatologists) are in the network.

THREE WAYS TO MAKE SURE YOU ARE USING NETWORK PROVIDERS

1. Log in to www.anthem/ca.com and select Blue Cross PPO (Prudent Buyer) – Large Group as the plan/network type, or access Anthem's mobile app on your smartphone. Pick the Find a Doctor tool to search for network providers and facilities.

2. Select Large Group Prudent Buyer.

3. Remind your doctor and other health care providers to refer you to network providers only. Always confirm for yourself when scheduling an appointment with a new provider.

4. Call the Member Services number on your ID card and ask them to check for you.

Anthem Benefit Advisor (ABA)

Navigating the healthcare system can often be very overwhelming and frustrating. This is why the Board of Trustees implemented the "Anthem Benefits Advisor" (ABA). ABA will be available to guide you through the process of choosing PPO providers, comparing your treatment options, and making helpful suggestions to enable you to make the most of the benefits offered by the Fund. When you need care, we encourage you to contact the ABA by calling 1-844-437-0488 Monday – Friday, 5AM-8PM PST (closed holidays), and support is available in Spanish if needed. An ABA agent will be available to:

- evaluate treatment options;
- offer details on quality providers and cost comparisons;
- offer coaching and education on plan details;
- connect you with other programs, tools and resources that are covered by your benefits;
- provide follow up regarding your treatment and questions.

This program is FREE and VOLUNTARY.

As you know, the Fund implemented a reference based pricing program for certain outpatient procedures performed in an outpatient hospital rather than an Ambulatory Surgical Center (ASC). In addition, there is a maximum facility payment for a single hip joint replacement or a single knee joint replacement surgery. If you are scheduled to have one of the surgeries listed above, call the ABA prior to the surgery so you may be directed to an ASC for the outpatient procedure or a Value Based Facility for the hip or knee replacement. If you do not use an ASC or Value Based Facility for the procedures identified above, you will be responsible for charges in excess

of the Plan limits set forth above (and excluded amounts do not accumulate to your out-of-pocket maximum).

Direct Pay Medical Plan C 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
3. 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 for your Dependents, confinements are separated by at least three months.
4. Preadmission testing for outpatient diagnostic x-ray and/or laboratory testing prior to and in conjunction with a scheduled hospitalization.
5. 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.
6. 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.
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.
6. Facility-based treatment of mental health and/or substance abuse (such as partial hospitalization and/or intensive outpatient treatment).

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. Allowed Charges 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.

Value Based Programs

The facility charges associated with certain surgical procedures are subject to a maximum Allowed Charge. The maximum is the most that the Plan will pay for the facility and certain other charges for:

Inpatient Hospital Procedures (for California Only):

- Total Hip Replacement Surgery (facility and required prosthesis charges)
- Total Knee Replacement Surgery (facility and required prosthesis charges)

Please note:

- The maximum for Total Hip and Total Knee replacements only apply **in the state of California.**
- The maximum **does not apply** to the above outpatient procedures if they are performed at a licensed ambulatory surgical center. If you have your total hip replacement or total knee replacement surgery at a licensed ambulatory surgery center, normal Plan benefits apply.
- The maximum does not apply to charges from medical providers including, but not limited to, surgeons, assistant surgeons, anesthesiologists, etc.

Value Based Site

In order to manage the cost variance for hip and knee replacement surgeries, the Fund will allow a maximum payment of $30,000 maximum for a single hip joint replacement or a single knee joint replacement surgery. The maximum Allowed Charge ***only*** applies to inpatient hospital surgeries for **total hip replacement and total knee replacement**, as well as for the prostheses required for the surgeries. Both surgeries must be preauthorized by Anthem Blue Cross in order to avoid an additional penalty.

If a total hip replacement or total knee replacement surgery is performed at a PPO facility, you have the choice of using a Value Based Site to ensure the lowest cost to you for the surgery. A Value Based Site is one that has contractually agreed not to exceed the Plan's maximum Allowed Charge for these procedures. **If you choose to use a PPO Hospital that is not a Value Based Site, you will increase your financial responsibility.**

For a hip or knee replacement, the Plan will apply benefits to the lesser of the maximum Allowed Charge or the PPO contracted rate if the surgeries are performed at either a Value Based Site or at a PPO hospital that is not a Value Based Site.

If the surgeries are performed at a Non-PPO Hospital, you are responsible for payment of your Coinsurance applied to the Allowed Charges plus 100% of any amounts above the Allowed Charges. Allowed Charges will not be more than the MAC.

Outpatient Surgical Procedures (if performed at an outpatient Hospital instead of an ambulatory surgical center):

- Arthroscopy (facility charges)
- Cataract Surgery (facility charges)
- Colonoscopy (facility charges)

Please note:

- The maximum **does not apply** to the above outpatient procedures if they are performed at a licensed ambulatory surgical center.
- The maximum does not apply to charges from medical providers including, but not limited to, surgeons, assistant surgeons, anesthesiologists, etc.

Any amounts excluded as being over the maximum Allowed Charge MAC do not accumulate to your annual Out-of-Pocket maximum.

Outpatient Hospital vs. Ambulatory Surgical Center

The following maximum Allowed Charges *only* applies to outpatient arthroscopy, cataract surgery, and colonoscopies **performed in the outpatient department of a Hospital.** If you have your colonoscopy, arthroscopy or cataract surgery at a freestanding ambulatory surgery center, normal Plan benefits apply. The maximum Allowed Charge for the following surgeries performed in the outpatient department of a Hospital are:

- Colonoscopy $1,500
- Arthroscopy $6,000
- Cataract Surgery $2,000

- For arthroscopies, cataract surgeries, and colonoscopies **performed in the outpatient department of a PPO Hospital**, the Plan **will allow the lesser of the maximum Allowed Charge or the PPO contracted rate (after Deductible)**.
- For arthroscopies, cataract surgeries, and colonoscopies **performed at a PPO freestanding ambulatory surgical center,** the Plan **will allow normal plan benefits (not subject to the maximum Allowed Charge).**
- For arthroscopies, cataract surgeries, and colonoscopies **performed at the outpatient department of a Non-PPO Hospital or Non-PPO surgery center**, you are responsible for any amount over the $500 maximum (after Deductible).

Exceptions Process

The inpatient and outpatient services provided by a provider, hospital, or outpatient surgery center that has not agreed to accept the maximum Allowed Charge may be paid at normal plan benefits for a PPO or Non-PPO provider if:

- Your access to a provider, hospital, or outpatient surgery center is unavailable or the service cannot be obtained within a reasonable wait time or travel distance; and
- The quality of services for you or your Dependents could be compromised with the provider, hospital, or outpatient surgery center (e.g., if co-morbidities present complications or patient safety issues).

Additional Information

Upon request, Anthem will provide you with:

- A list of hospitals that accept the maximum Allowed Charge for a particular inpatient service (also known as Value Based Sites);
- A list or hospitals that will accept a negotiated price above the Allowed Charge; and
- Information on the process and underlying data used to ensure that an adequate number of hospitals that accept the Allowed Charge meet reasonable quality standards.

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

The wellness/preventive services payable by the Fund are designed to comply with Health Reform regulations and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), and the Centers for Disease Control and Prevention (CDC). Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of preventive care services, the Fund will comply with the new requirements on the date required.

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.

The following websites (which are periodically updated by government agencies) list the types of covered preventive services for non-grandfathered medical plans like ours:

- https://www.healthcare.gov/what-are-my-preventive-care-benefits,
- http://www.uspreventiveservicestaskforce.org/BrowseRec/Index (current list of A and B recommendations)
- https://www.hrsa.gov/womens-guidelines/index.html and
- http://www.cdc.gov/vaccines/schedules/index.html?s_cid=cs_001

Covered Preventive Services for Adults

- Abdominal Aortic Aneurysm one-time ultrasonography screening for men ages 65-75 who have ever smoked;
- Alcohol Misuse screening and counseling for adults age 18 and older. Clinicians to provide such screening and interventions to reduce alcohol misuse;
- Blood Pressure screening in adults age 18 and older. Blood pressure screening is not payable as a separate claim, as it is included in the payment for a physician/health care provider office visit;
- Cholesterol screening (Lipid disorders screening) for adults aged 40 to 75 years;

- Colorectal Cancer screening using fecal occult blood testing, sigmoidoscopy, or colonoscopy, in adults beginning at age 50 and continuing until age 75. The Fund will not impose cost-sharing with respect to a polyp removal during a colonoscopy performed as a screening procedure, pre-procedure specialist consult, pathology exam or anesthesia;
- Depression screening for adults;
- Type 2 Diabetes screening for asymptomatic adults over 40 who are overweight or obese;
- Diet counseling for adults at higher risk for chronic disease;
- HIV screening for all adolescents and adults ages 15 to 65 and for younger and older participants who are at higher risk;
- Obesity screening (including measurement of BMI) and intensive counseling and behavioral interventions to promote sustained weight loss for overweight or obese adults;
- Sexually Transmitted Infection (STI) prevention counseling for adults at higher risk;
- Tobacco Use screening for all adults and cessation interventions for tobacco users. This includes screening for tobacco use; and for tobacco users, at least two tobacco cessation attempts per year. A "tobacco cessation attempt" includes coverage for **four (4) tobacco cessation counseling sessions** of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization.
- Syphilis screening for all adults at increased risk of infection.
- Counseling for young adults to age 24 who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Exercise or physical therapy to prevent falls in community-dwelling adults age 65 years and older who are at increased risk for falls.
- Screening for hepatitis C virus (HCV) infection in persons at high risk for infection and a one-time screening for HCV infection in adults born between 1945 and 1965.
- Annual screening for lung cancer with low-dose computed tomography in adults ages 55 to 80 years who have a 30 pack/year smoking history and currently smoke or have quit within the past 15 years.

See also the coverage for certain preventive care drugs in the Prescription Drug chapter of this document beginning on page 39.

Covered Preventive Services for Women, Including Pregnant Women

- Well woman office visits for women beginning in adolescence, for the delivery of required preventive services;
- Bacteriuria screening for pregnant women. Screening for asymptomatic bacteriuria with urine culture for pregnant women is payable at 12 to 16 weeks' gestation or at the first prenatal visit, if later;
- BRCA counseling about genetic testing for women at higher risk. Women whose family history is associated with an increased risk will receive a referral for counseling. The Fund will also cover BRCA 1 or 2 genetic tests without cost-sharing (at a PPO provider) if appropriate as determined by the woman's health care provider;
- Breast cancer screening mammography for women with or without clinical breast examination and with or without diagnosis, every year for women aged 40 and older;
- Breast cancer chemoprevention counseling for women at higher risk. The Fund will pay for counseling by physicians with women at high risk for breast cancer and at low risk for adverse effects of chemoprevention, to discuss the risks and benefits of chemoprevention.

For women at increased risk for breast cancer and at low risk for adverse medication effects, risk-reducing medications such as tamoxifen or raloxifene will be covered;

- Breastfeeding counseling: Comprehensive lactation support and counseling by a trained provider during pregnancy and/or for the duration of breastfeeding, and costs for renting breastfeeding equipment. The Fund may pay for purchase of breastfeeding equipment instead of rental, if deemed appropriate by the Administrative Office;
- Cervical cancer screening for women ages 21-65 once every 3 years;
- Human papillomavirus (HPV) testing for women ages 30 and older with normal Pap smear results, once every three years as part of a well woman visit;
- Chlamydia Infection screening for all sexually active non-pregnant young women aged 24 and younger, and for older non-pregnant women who are at increased risk, as part of a well woman visit. For all pregnant women aged 24 and younger, and for older pregnant women at increased risk, chlamydia infection screening is covered as part of the prenatal visit;
- FDA-approved contraceptives methods, sterilization procedures, and patient education and counseling for women of reproductive capacity. FDA-approved contraceptive methods, include barrier methods, hormonal methods, and implanted devices, as well as patient education and counseling, as prescribed by a health care provider. The Fund will cover a generic drug without cost sharing (and a brand drug if a generic is medically inappropriate). Services related to follow-up and management of side effects, counseling for continued adherence, and device removal are also covered without cost sharing.
- Folic acid supplements for women who are planning or capable of pregnancy are covered (see chart outlining coverage of preventive care drugs on page 40);
- Gonorrhea screening for all sexually active women, including those who are pregnant, age 24 or younger or, if they are at increased risk for infection for women 25 and older, provided as part of a well woman visit. The Fund will pay for the most cost-effective test methodology only;
- Counseling for sexually transmitted infections, once per year as part of a well woman visit;
- Counseling and screening for HIV, once per year as part of a well woman visit, and for pregnant women, including those who present in labor who are untested and whose HIV status is not known;
- Hepatitis B screening for pregnant women at their first prenatal visit;
- Osteoporosis screening for women age 65 and older (younger women will be eligible for screening if their risk of fracture is equal to or greater than that of a 65-year old woman). The Fund will pay for the most cost-effective test methodology only;
- Rh Incompatibility screening for all pregnant women during their first visit for pregnancy related care, and follow-up testing for all unsensitized Rh (D) negative women at 24-28 weeks' gestation, unless the biological father is known to be Rh (D) negative;
- Screening for gestational diabetes in asymptomatic pregnant women between 24 and 28 weeks' gestation and at the first prenatal visit for pregnant women identified to be at risk for diabetes;
- Tobacco Use screening and interventions for all women, as part of a well woman visit, and expanded counseling for pregnant tobacco users;
- Syphilis screening for all pregnant women or other women at increased risk, as part of a well woman visit;

- Screening and counseling for interpersonal and domestic violence, beginning in adolescence, as part of a well woman visit;

Covered Preventive Services for Children

- Well baby and well child visits from ages newborn through 21 years as recommended for pediatric preventive health care by "Bright Futures/American Academy of Pediatrics." Visits will include the following age-appropriate screenings and assessments: Developmental screening for children under age 3, and surveillance throughout childhood, behavioral assessments for children of all ages, medical history, blood pressure screening, depression screening (for major depressive disorder) for adolescents ages 11 and older, vision screening, hearing screening, height, weight and body mass index measurements for children, autism screening for children at 18 and 24 months, alcohol and drug use assessments for adolescents, critical congenital heart defect screening in newborns, hematocrit or hemoglobin screening for children, lead screening for children at risk of exposure, tuberculin testing for children at higher risk of tuberculosis, dyslipidemia screening for children at higher risk of lipid disorders, depression screening beginning at age 11, oral health assessment for children 10 years and younger, obesity screening and counseling, hepatitis B screening for adolescents at high risk, sexually transmitted infection (STI) screening and counseling for sexually active adolescents, cervical dysplasia screening for sexually active females and an oral health risk assessment;
- Newborn screening tests recommended by the Advisory Committee on Heritable Disorders in Newborns and Children (such as hypothyroidism screening for newborns and sickle cell screening for newborns);
- Prophylactic ocular topical medication for all newborns for the prevention of gonorrhea;
- Oral fluoride varnish application at currently recommended doses (based on local water supplies) to preschool children older than 6 months of age whose primary water source is deficient in fluoride;
- Screening for iron supplementation for asymptomatic children aged 6 to 12 months who are at increased risk for iron deficiency anemia;
- Obesity screening for children aged 6 years and older, and counseling or referral to comprehensive, intensive behavioral interventions to promote improvement in weight status; and
- HIV screening for adolescents ages 15 and older and for younger adolescents at increased risk of infection.
- Counseling for children, adolescents, and young adults ages 10 to 24 years who have fair skin about minimizing their exposure to ultraviolet radiation to reduce risk for skin cancer.
- Interventions, including education or brief counseling, to prevent initiation of tobacco use in school-aged children and adolescents.

Immunizations

Routine immunizations are covered for participants and dependents who meet the age and gender requirements and who meet the CDC medical criteria for recommendation:

- Immunization vaccines for adults including diphtheria/tetanus/pertussis, measles/mumps/rubella (MMR), influenza, human papillomavirus (HPV), pneumococcal (polysaccharide), zoster, hepatitis A, hepatitis B, meningococcal and varicella.

- Immunization vaccines for children from birth to age 18 including hepatitis B, rotavirus, diphtheria, tetanus, pertussis, haemophilus influenza type b, pneumococcal, inactivated poliovirus, influenza, measles, mumps, rubella, varicella, hepatitis A, meningococcal, human papillomavirus (HPV)

Please note: immunizations that are required for foreign travel are not covered.

Office Visits associated with Preventive Care

When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. copay, coinsurance and deductible) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. copay, coinsurance and deductible) will apply to the diagnostic or therapeutic services provided.

For example, if a person has a cholesterol screening test during an office visit, and the doctor bills for the office visit and separately for the lab work associated with the cholesterol screening test, the Fund will charge a copayment for the office visit but not for the lab work. If a person sees a doctor to discuss recurring abdominal pain and has a blood pressure screening during that visit, the Plan will charge a copayment for the office visit because the blood pressure check was not the primary purpose of the office visit.

Well child annual physical exams recommended in the Bright Futures Recommendations are treated as preventive services and paid at 100%.

Professional Services and Supplies

1. Services rendered by a Physician, subject to the limitations and exclusions in the Plan.
2. LiveHealth Online visit (subject to a $20 copay and the deductible waived);
3. Services rendered by a provider who is acting within the scope of their license under the laws of the state or jurisdiction where the services are rendered, and who are providing a Medically Necessary otherwise covered service.
4. 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.
3. Services related to acupuncture, if performed by a provider who is practicing within the scope of his or her license and providing a Medically Necessary covered service, and for treatment of pain only. Limited to twelve (12) visits per calendar year.
4. 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 preauthorized by the Review Organization. Services rendered must not be custodial in nature and not able to be performed by a less qualified person.
5. Services related to acupuncture, if performed by a provider who is practicing within the scope of his or her license and providing a Medically Necessary covered service, and for treatment of pain only. Limited to twelve (12) visits per calendar year.
6. 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 preauthorized by the Review Organization. Services rendered must not be custodial in nature and not able to be performed by a less qualified person.
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 one calendar year. The Rehabilitative Therapy for the 24 visits must be for medically necessary treatment of the condition requiring surgery, or medically necessary treatment to restore function following stroke or surgery. This stroke/surgery benefit for 24 outpatient Rehabilitative Therapy visits is independent of the Plan's overall benefit for outpatient Rehabilitative Therapy unrelated to stroke or surgery, of up to 12 visits per calendar year.
9. 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.
8. 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 preauthorized by the Review Organization.
9. Rental or purchase of prosthetic devices, medical equipment and supplies. Allowed Charges 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 Allowed Charges.

10. Sterilization procedures (for men) and abortions for the Employee or Spouse only. Please note that female sterilization procedures with a PPO provider are covered under the preventive care benefits.
11. 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***. Allowed Charges 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. The maximum payment of $400 is limited to one charge every 36 months. Hearing aids are limited to one of the following models:

- in-the-ear,
- behind-the-ear,
- on-the-body, and
- in the eyeglass temple.

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 C only for eligible Dependent Children enrolled in that Plan and only for congenital hearing deficits.

Patient Protection Rights of the Affordable Care Act

The medical plans in this document do not require the selection or designation of a primary care provider (PCP). You have the ability to visit any network or Non-PPO health care provider; however, payment by the Plan may be less for the use of a Non-PPO provider.

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior

authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact Anthem at the number listed at the front of this SPD.

Nondiscrimination in Health Care

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

Health Dynamics Free Exam

Please note: this Health Dynamics exam does NOT apply to Participants who are enrolled in the Kaiser HMO (subject to change in the future).

The Fund offers a comprehensive health exam through Health Dynamics that provides covered employees and spouses (or Domestic Partners). The Health Dynamics health evaluation is **absolutely free** and will provide you with a health profile that identifies any potential health concerns, and assesses your nutritional status and fitness and helps keep you on track to maintain optimal health.

More exam details: The exam typically takes about two hours to complete. It begins with a questionnaire and includes a physician-directed physical, a lab panel that is likely more extensive than you would routinely obtain from your primary-care physician and tests that evaluate your heart, lungs and potential cancer risks. Nutritional intake, cardiovascular fitness, strength, flexibility, body composition and stress inventory are also tested. After completing your exam, you may participate in a personal-consultation session with a health educator to review the results. Your educator will make recommendations and suggestions specific to your unique health, fitness and nutritional status. Knowing what you need to do is essential to improving or maintaining your health.

Find a participating provider in your area by calling Health Dynamics at 866-443-0164, option 1.

Notice Regarding Wellness Program

The Health Dynamics Program is a voluntary wellness program available to all participants and eligible spouses in the Automotive Industries Welfare Fund. The program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the wellness program you will be asked to complete a voluntary questionnaire that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You will also be asked to complete a biometric screening, which will include a blood test that is likely more extensive than you would routinely obtain in order to determine certain health risks. You are not required to complete the questionnaire or to participate in the blood test or other medical examinations.

The information from your questionnaire and the results from your biometric screening will be used to provide you with information to help you understand your current health and potential risks. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the wellness program and Automotive Industries Welfare Fund may use aggregate information it collects to design a program based on identified health risks in the workplace, the Health Dynamics Program will never disclose any of your personal information either publicly, to the Fund or to the employer, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the wellness program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the wellness program will not be provided to the Fund, your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the wellness program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the wellness program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the wellness program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is the Health Dynamics health educator in order to provide you with services under the wellness program.

In addition, all medical information obtained through the wellness program will be maintained separate from your Fund records and personnel records, information stored electronically will be encrypted, and no information you provide as part of the wellness program will be used in making any Fund benefit decision or employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the wellness program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the wellness program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Fund Office at (800) 635-3105.

Utilization Review Programs

Inpatient Preauthorization and Utilization Review

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.

In addition to inpatient confinements, the following services must be preauthorized in order to avoid a $250 penalty:

- Repeat imaging;
- Home healthcare;
- Home infusion therapy; and
- Hospice care;

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.**

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 C 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 C 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 Allowed Charge. 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.

General Direct Pay Medical Plan C 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 worker's 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 unless such injury or illness is the result of domestic violence or the commission or attempted commission of an assault or felony is the direct result of an underlying health factor.
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 C benefits.
15. Services to reverse voluntary, surgically-induced infertility.
16. 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.
17. Services or supplies considered by the Plan to be Experimental or not generally accepted in medical practice.
18. Custodial or non-skilled care or rest cures, care in a home for the aged, nursing, rest home, or institution of a similar character, except as specifically provided in the Plan.

19. Screening of potential donors other than the donor actually used for transplantation of human organs or tissue.
20. 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).
21. 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 (except as required under health reform), food supplements, exercise and physical fitness programs or equipment, orthopedic shoes, wigs and supplies for comfort, hygiene or beautification.
22. Massage Therapy.
23. Emergency room charges for treatment that is not considered to be a true Emergency Medical Condition.
24. Immunizations for foreign travel.
25. Expenses for medical services or supplies rendered or provided outside the United States, except for treatment for an Emergency Medical Condition.
26. Vasectomies and abortions for Dependent Children.
27. Any custodial care charges.
28. 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. This exclusion does not apply to the extent that it constitutes screening and counseling for obesity or otherwise qualifies preventive care under health reform.
29. 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.
30. Charges for gamma globulin injections as a preventive measure.
31. Charges for amniocentesis, unless the patient is 35 years or older, or if under age 35 has a previous afflicted child.
32. Charges for services associated with sex transformations and resulting complications.
33. 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.
34. All services relating to pre-marital, driver's license, school entry or sports examinations.
35. Charges for care or treatment in any penal institution or jail facility or jail ward of any state or political subdivision unless the services are both Medically Necessary and a covered benefit of the Plan.
36. Charges for hypnotism, stress management, biofeedback treatment and any other goal oriented behavior modification therapy.
37. Marriage and Family Counseling.
38. Treatment for Temporomandibular Joint Syndrome (TMJ).
39. 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 C only for Dependent Children diagnosed with a congenital hearing deficit that cannot be treated with a hearing aid.

40. 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.
41. Conjoint Therapy (where the Physician sees the family members without the patient being present).
42. Educational Services such as auditory or speech aids (including computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, synthesizers, auxiliary aids such as communication boards, and listening systems), auditory perception or listening/learning skills and/or programs and services to remedy or enhance concentration, memory, motivation, reading or self-esteem.
43. Expenses for habilitation services (to help individuals attain certain functions that they never have acquired) including treatment of delays in childhood speech and physical development.

Member Assistance Program

These benefits are provided through Managed Health Network (MHN) and are available to <u>Employees</u> who are enrolled in the Direct Pay Medical Plan C or the Kaiser HMO Plan Enrollees. Dependents are not eligible for the Member Assistance Program benefits.

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

Fee-For-Service Prescription Drug Benefits

These benefits are provided through Optum Rx and are available to all Direct Pay Medical Plan C Enrollees. If you are enrolled in the Kaiser HMO, your prescription drug benefits are available through Kaiser.

Prescription Drug Manager

The Fee-For-Service Prescription Drug Plan covers participants who are enrolled in the Direct Pay Medical Plan C.

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan has contracted with ***Optum Rx*** 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.

Following is a summary of your outpatient prescription drug benefits:

<table>
<tr><th colspan="3">Prescription Drug Summary of Benefits</th></tr>
<tr><th></th><th>In-Network</th><th>Out-of-Network</th></tr>
<tr><td>Calendar Year Deductible</td><td colspan="2">None</td></tr>
<tr><td>Calendar Year Out-of-Pocket limit</td><td>$1,500/individual
$4,500 family of three or more</td><td>None (charges will never be paid at 100%)</td></tr>
<tr><td colspan="3">Retail Pharmacy (30-day supply)</td></tr>
<tr><td>Formulary Generic</td><td>20% plus $5 copay</td><td rowspan="3">Participant pays 100% and must file a claim with the PBM</td></tr>
<tr><td>Formulary Brand</td><td>20%</td></tr>
<tr><td>Non-Formulary</td><td>20% plus $15 copay</td></tr>
<tr><td colspan="3">Mail Order Pharmacy (90-day supply)</td></tr>
<tr><td>Formulary generic</td><td>$40 copay</td><td rowspan="2">Participant pays 100% and must file a claim with the PBM</td></tr>
<tr><td>Brand-name drugs</td><td>$60 copay</td></tr>
<tr><td>Specialty Drugs</td><td>20% (up to a $100 maximum copay)</td><td>Not covered</td></tr>
<tr><td colspan="3">Maximum copay of $100 per brand name prescription if the brand name drug is unavailable as generic and unavailable through mail order.</td></tr>
</table>

Coverage of Certain Preventive Care Drugs

In accordance with Health Reform, **certain preventive care drugs** are payable with no cost sharing when prescribed by a Physician or Health Care Practitioner. **For a preventive care drug to be covered by the Fund, the drug must be:**

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

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

Preventive Care Drug Name *	Who Is Covered for this Drug?	Payment Parameters for Generic preventive care Drugs
Aspirin	Covered for preeclampsia prevention for pregnant women who are at high risk for preeclampsia. Also, low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.	Since dosage is not established by USPSTF, plan covers up to one bottle of generic 100 tablets every 3 months
OTC Contraceptives for females, such as spermicidal products and sponges.	All females	Generic FDA approved contraceptives are no cost. Brand contraceptives are payable only if a generic alternative is medically inappropriate.
Folic acid supplements containing 0.4 - 0.8mg of folic acid	All females planning or capable of pregnancy should take a daily folic acid supplement.	Since dosage is not established by USPSTF, plan covers up to one bottle of 100 tablets every 3 months
Vitamin D supplements	For adults age 65 and older who are at increased risk for falling.	Since dosage is not established by USPSTF, plan covers up to one bottle of 100 tablets every 3 months
Tobacco cessation products	Individuals who use tobacco products.	Two 12-week courses of treatment per year, which applies to all FDA approved tobacco cessation medications (prescription and over-the-counter) when prescribed by a health care provider.

Preventive Care Drug Name *	Who Is Covered for this Drug?	Payment Parameters for Generic preventive care Drugs
Fluoride supplements	For preschool children older than age 6 months when recommended by provider because primary water source is deficient in fluoride.	Plan covers generic versions of dietary fluoride supplements (tablets, drops or lozenges) available only by prescription for children to age 6 years.
Preparation "prep" Products for a Colon Cancer Screening Test	For individuals receiving a preventive colon cancer screening test	Plan covers the over-the-counter or prescription strength products prescribed by a physician as preparation for a covered preventive colon cancer screening test, such as a colonoscopy.
Breast cancer medications for risk reduction for primary breast cancer in women	Women who are at increased risk of breast cancer	Fund covers risk-reducing medications, such as tamoxifen or raloxifene.
Statin preventive medication	Adults 40-75	Plan covers for adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater

* Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of preventive care drugs, this Fund will comply with the new requirements on the date required.

"New-to-Market" Drugs

As you know, the Fund contracts with OptumRx, a prescription benefit management firm, to administer the Prescription Drug benefit for our participants. Any medication that is newly-approved by the U.S. Food and Drug Administration (FDA) to enter the market is not covered by the Fund until after OptumRx has had a chance to review the evidence and overall clinical value when compared to other alternatives in the market. This means that if you attempt to fill a prescription for one of these "new to market" drugs, before OptumRx has completed its review, there will be no payment by the Fund.

Preferred Alternative Drugs

Within each drug category, there are many therapeutic alternative drugs available. If you are taking a prescription drug for one of the therapeutic categories, you will be contacted by Optum. In this case, the Fund will only provide coverage for the preferred alternative. If you attempt to fill a prescription for one of the "Excluded Medications," there will be no payment by the Fund. This does not mean you should stop taking your medication, we recommend that you talk to your doctor to discuss alternative covered medication options.

Step Therapy Drugs

Under the Step Therapy program, you may be required to try a Preferred Medication before the Fund will cover the Non-Preferred medication. If you have already tried the "first line" medication, or if your doctor decides that a different drug is needed, he or she can request a prior authorization by contacting Optum Rx. Please note: Any approved second line drugs may be subject to a higher copay; if the request is not approved, you will be responsible for the full price of the drug. Your provider can request prior authorization by contacting Prescription Solutions at 1-855-427-4682.

Appeals

If your Physician feels that you must have access to a "new to market" medication before OptumRx completes its review, or that you must have access to an Excluded Medication instead of the Preferred Alternative, you may file an appeal with the Fund.

You can call the member services number at Optum Rx 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, you must show the pharmacist your ID card and pay your copay requirement for up to a 30-day supply. You will not be required to pay more than the full cost of the drug if this is less than the copay.

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 Optum Rx for direct reimbursement.

Mail Order Pharmacy Program

Save time and money by not driving to the pharmacy. OptumRx® Mail Service Pharmacy provides many benefits to members for those members on maintenance medications. Don't miss out on the savings that come with Mail Service and the convenience of having medications delivered right to your door. In addition, you are entitled to a free **personalized medication review.** OptumRx has friendly customer service advocates available to take your call. You can contact a licensed pharmacist 24 hours a day, 7 days a week, by phone 1-855-427-4682. OptumRx is always here to help you, even after you have received your medications. There is never a charge for standard shipping.

When you order by mail, you can get up to a 90-day supply. Mail order drugs are delivered directly to your home. You will not be required to pay more than the full retail cost of the drug.

Specialty Pharmacy and Clinical Management Program

OptumRx™ Specialty Pharmacy is the Fund's provider for specialty medications. Specialty Drugs are very high cost prescriptions that can include some injectables, inhalants and oral medications. Please note:

- Specialty drugs are limited to a 30-day supply.
- Specialty drugs must be filled using the OptumRx Specialty Mail Order Pharmacy.
- Shipping is at no charge to you for your 30-day supply.
- Participants taking HIV/AIDS medications can opt-out of this program by calling 1-877-839-7045.

The ***Clinical Management Program (CMP)*** provides extra support at no cost to individuals

with a condition requiring specialty medications. Members who enroll in a CMP will receive regularly scheduled phone calls with a personal clinician. These calls focus on helping members to better understand their condition and medications, teach ways to manage side effects, and provide other resources to help patients take a more active role in their treatment. **Participation is completely voluntary.**

To enroll, call the OptumRx Specialty Pharmacy at 1-877-839-7045. Ongoing support includes:

- One-on-one phone consultations with a pharmacist or nurse who is specially trained in your condition.
- During the first consultation, the nurse or pharmacist collects important background and medical information from you in order to learn about your unique needs and determine the best method of support for you.
- Follow-up consultations are scheduled as necessary
- Education materials and resources

Clinical Management Programs are available for a number of conditions including:

- Ankylosing spondylitis
- Hemophilia
- HIV/AIDS
- Multiple sclerosis
- Transplant
- Psoriatic arthritis
- Rheumatoid arthritis
- Crohn's Disease
- Hepatitis C
- Juvenile rheumatoid arthritis
- Oncology
- Psoriasis

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.
* 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.

Compound Medication Exclusion

Compound medications are medications with one or more ingredients that are prepared "on-site" by a pharmacist using bulk chemicals. Many bulk chemicals are not approved by the Food and Drug Administration (FDA). No compound medication will be considered covered if any of the ingredients in the compound medication are either 1) not approved by the FDA *or* 2) if any of the ingredients are separately excluded under the Plan.

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 Optum Rx, you will need to fill out an Optum Rx claim form. The claim form is available on the Optum Rx website at www.optumrx.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:

Optum Rx
Attention: Claims Department
P.O. Box 6037
Cypress, CA 90630-0037

Automotive Industries Welfare Fund has determined that the prescription drug coverage under the following prescription drug plan options (the Direct Pay Plan, and the Kaiser 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

The Automotive Industries Welfare Fund 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 health Plan provided by Automotive Industries Welfare Fund and is designed to provide reimbursement of certain Eligible Medical Care Expenses for eligible HRA Employees. 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 Fund. This means that Employees may not participate in the HRA Plan without also participating in the Medical Plan sponsored by Automotive Industries Welfare Fund.

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 Fund.

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 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 Fund.

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 Fund.

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.

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 forfeit the unused amount in your HRA Account. Any unused amounts in your HRA Account at the end of the year **will not** be carried over into the next calendar year.

Upon termination of your participation in Plan C, your HRA 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.

Prepaid Benefits Card

The Prepaid Benefits Card is a special-purpose MasterCard or Visa that gives you an easy way to pay for eligible expenses. The value of your HRA Account will be stored on the card. When you have an eligible expense at a business that accepts MasterCard debit cards or Visa Debit Cards, just use your card (if there is a choice of "debit" or "credit", choose "credit") and funds are automatically deducted from your HRA Account.

A lost or stolen Prepaid Benefits Card

If you lose your Prepaid Benefits Card or it is stolen, call the Trust Fund Office immediately to let them know. The account will be turned off and the card will be replaced.

Where can the Prepaid Benefits Card be used?

IRS regulations allow you to use your Prepaid Benefits Card in participating pharmacies, mail-order pharmacies, discount stores, department stores and supermarkets that can identify HRA-eligible items as checkout. You may also use the card to pay a hospital, doctor, dentist, or vision provider that accepts MasterCard or Visa.

The card will not be accepted at locations that do not offer the eligible goods and services such as hardware stores, restaurants, bookstores and gas stations.

Save All of Your Itemized Receipts

You should always save itemized receipts for purchases made with the card. You may be asked to submit receipts to verify your expenses comply with IRS guidelines. Each receipt must show:

- the merchant or provider name;
- the service received or the item purchased; and
- the date and the amount of the purchase.

Forfeitures

If your eligibility terminates and you have remaining credits in your HRA account, those amounts will be forfeited at the end of the month following the month in which your eligibility terminates.

The only exceptions to this procedure are if you elect COBRA Continuation Coverage or in the event of your death.

- If you elect COBRA Continuation Coverage, you will be entitled to continue to receive reimbursements from the HRA Account until the earlier of the date the HRA Account reaches a zero balance or the end of the COBRA Continuation Coverage period.
- In the event of your death, your surviving Dependents may elect COBRA in order to be entitled to reimbursements from the deceased participant's remaining HRA Account balance until the earlier of the date the HRA Account reaches a zero balance or the end of the COBRA Continuation Coverage period..

If COBRA is not elected, any remaining credits in your account will be forfeited at the end of the month following the month in which your eligibility terminates. Forfeitures become the property of the Fund as administered by the Board of Trustees.

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 Kaiser, you will not be able to use your previously accrued HRA funds while enrolled in Kaiser. 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, diabetic supplies, device to measure blood pressure, fertility treatment, surgical dressing supplies, elastic bandages like an Ace wrap, hearing aids, immunizations and flu shots, laboratory tests, tobacco cessation drugs, walker/wheelchair and weight loss programs/weight loss drugs only if recommended by a Physician to treat a specific medical condition (e.g. diabetes, obesity, heart disease).

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

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

Excludable Expenses

The following expenses are examples of the kinds of expenses that are not reimbursable, as they do not meet the definition of "medical care" under Code Section 213. This is not intended to be a complete list of all services that are not payable under the 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. Health club or fitness program dues.
8. Costs for sending a child with behavioral problems to a school for benefits that the child may receive from the course of study and/or disciplinary methods if the availability of medical care in the school isn't a principal reason for sending the student there.
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 expenses.

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.

Prepaid Benefits Card

The Prepaid Benefits Card is a special-purpose MasterCard or Visa that gives you an easy way to pay for eligible expenses. The value of your HRA Account will be stored on the card. When you have an eligible expense at a business that accepts MasterCard debit cards or Visa Debit Cards, just use your card (if there is a choice of "debit" or "credit", choose "credit") and funds are automatically deducted from your HRA Account.

A lost or stolen Prepaid Benefits Card

If you lose your Prepaid Benefits Card or it is stolen, call the Trust Fund Office immediately to let them know. The account will be turned off and the card will be replaced.

Where can the Prepaid Benefits Card be used?

IRS regulations allow you to use your Prepaid Benefits Card in participating pharmacies, mail-order pharmacies, and supermarkets that can identify HRA-eligible items as checkout. You may also use the card to pay a hospital, doctor, dentist, or vision provider that accepts MasterCard or Visa.

The card will not be accepted at locations that do not offer the eligible goods and services such as hardware stores, restaurants, bookstores and gas stations.

Save All of Your Itemized Receipts

You should always save itemized receipts for purchases made with the card. You may be asked to submit receipts to verify your expenses comply with IRS guidelines. Each receipt must show:

- the merchant or provider name;
- the service received or the item purchased; and
- the date and the amount of the purchase.

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 my 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, 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.

Exception: A new Employee may enroll in the Delta Dental PPO Plan rather than one of the pre-paid dental options if prior to enrolling in the Plan:

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

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.

1. 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. Questions of ineligibility should first be handled directly between you and 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 (www.deltadentalca.org) or write us at P. O. Box 997330, Sacramento, CA 95899-7330, Attn: 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.

Delta will provide the Enrollee a written acknowledgement within five calendar days of receipt of the request for review. It will render a decision and respond to you within 60 days of receipt of the request for review. Delta will respond within 72 hours to grievances involving severe pain and imminent and serious threat to a patient's health (urgent care grievance).

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 Fund for three (3) consecutive months.

Orthodontic benefits are treated as a standalone (or excepted) benefit under HIPAA and Health Reform. However, the Board of Trustees has decided to allow coverage for dependents up to age 26 even though it is not required to do so.

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 Fund dental options.

Orthodontic expense will not include expense 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 Fund, 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 Fund 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 not 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.

VSP benefits refresh every other year during the month of the last date of service. For example, if you receive vision services on July 1, 2017, you will be eligible for additional vision benefits in July of 2019.

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 $45 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 $30 per pair
- Lined Bifocal: up to $50 per pair
- Lined Trifocal: up to $65 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 $130 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 $70 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 $130 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 $45 for the comprehensive exam and up to $105 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)

Costco Providers

You may receive your covered vision services at Costco rather than with a VSP provider. Outlined below are some key differences between going to a traditional in-network VSP provider and Costco:

- If you use a VSP provider, you are still eligible for the additional discounts during the 2-year period outlined above. These discounts include 20% off additional glasses or sunglasses at the VSP provider's office, the Laser Vision Care program which provides members with an average of 15% off of laser vision correction at participating provider's offices (or an additional 5% off of any promotional specials that the VSP provider's office may be having), the TruHearing hearing aid discount, and VSP's Marchon20 program where you get an additional $20 towards featured frame brands at the time of service.
- Frames at Costco are covered at a lower retail amount than a frame from a VSP provider (the $130 VSP retail frame allowance will be $70 at Costco).
- VSP's discounts for lens enhancements such as progressives, scratch coating, polycarbonate lenses and anti-reflective coating are billed at Costco's regular charge for these cosmetic options. The cost at Costco tends to be less than what you see at a private practice office due to warehouse pricing.
- The additional discount of 20% off overage from frames (the amount over the retail frame allowance) is not available at Costco.
- The extra $20 VSP allowance to spend on featured frame brands does not apply at Costco.
- The additional 20% off additional pairs of glasses purchased within 12-months of exam does not apply at Costco.
- The capped retinal screen exam (at $39) is not available at Costco.

Please note that you must have a Costco membership in order to access the optical dispensary at Costco. A Costco membership is <u>not</u> required to receive an exam with the providers located at Costco. Please note that not all Costco providers are a part of VSP's retail network. If you are interested in using a Costco provider, please contact VSP at (800) 877-7195.

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 Allowed Charges were incurred. Benefits will not be allowed if you submit your claim more than 180 days after the date on which Allowed Charges 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

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 with in 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 Voya. 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 C benefits or Kaiser***

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

Schedule of Benefits

Employee Death Benefit	$2,500
Dependent Death 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 Voya; 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 Voya 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 Voya 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, Voya 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 Voya, 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 Voya 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 Voya 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 Voya 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 Voya 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 Voya receives a notice of claim, forms will be sent to you for providing Voya proof of loss. Voya will send these forms within 15 days after receiving a notice of claim. If Voya 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 Voya 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

Voya 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 Voya.

Legal Actions

Legal actions cannot be taken against Voya:

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 Voya. 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 C.

Employee Life Insurance Benefit

*You should refer to your **Certificate of Coverage** from Voya 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 Voya which will show the amount of your benefit. The amounts that can be negotiated by your employer are $5,000, $7,500, $10,000, $15,000, $20,000, $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:
  - Your spouse or domestic partner.
  - Your natural and adopted children.
  - Your parents.
  - Your estate.

The person must be living on the tenth day after your death. However, Voya 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.

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.

Dependent Life Insurance Benefit

The amounts of Dependent life insurance are as follows:

- Spouse or Domestic Partner - $500.
- Child:
    - From birth to six months of age - $500; or
    - From six months but less than 21 years (23 years if a fulltime student).

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 Voya; and
* pay the premium required.

You or your insured dependent may purchase any individual nonparticipating policy offered by Voya, except term insurance. The new policy must provide for a level amount of insurance and have premiums at least equal to those of Voya's whole life plan with the lowest premium. If your previous coverage included additional benefits such as disability, Accidental Death and Dismemberment Insurance or the Accelerated Death Benefit, the new insurance will not include these benefits.

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

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

Amount of Conversion Coverage

If your or your insured dependent's Life Insurance is changed or cancelled because the Group Policy is changed or cancelled, and your Life Insurance under the Group Policy has been in effect for at least 5 years in a row, the amount of the individual policy is limited to the lesser of:

- $5,000 or
- the amount of your or your insured dependent's Life Insurance which stops, minus the amount of other group insurance for which you or your insured dependent becomes eligible, within 31 days of the date your or your insured dependent's insurance stops.

If your or your Dependent's Life Insurance stops for any reason other than the above, the amount of your or your Dependent's individual policy may be any amount up to the amount of your or your Dependent's Life Insurance that stopped.

Accidental Death and Dismemberment Benefits for Employees

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

* You are covered for AD&D Insurance on the date of the accident.

* Loss occurs within 180 days of the date of the accident.
* The cause of the loss is not excluded.

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 AD&D Amounts

Voya pays the benefit shown below if you suffer any of the losses listed. Voya pays only one Full Amount while the Group Policy is in effect. If you have a loss for which Voya paid 1/2 of the Full Amount, Voya pays no more than 1/2 of the Full Amount for the next loss.

Loss	Benefit Amount
Loss of life	Full Amount
Loss of both hands, both feet or sight of both eyes:	Full Amount
Loss of one hand and one foot	Full Amount
Loss of speech and hearing in both ears	Full Amount
Loss of one hand or one foot and sight of one eye	Full Amount
Loss of one hand or one foot or sight of one eye	1/2 Full Amount
Loss of speech	1/4 Full Amount
Loss of hearing in both ears	1/4 Full Amount
Loss of thumb and index finger of same hand	1/4 Full Amount
Quadriplegia	Full Amount
Paraplegia	1/2 Full Amount
Hemiplegia	1/2 Full Amount

Loss of hands or feet means loss by being permanently, physically severed at or above the wrist or ankle. Loss of sight means total and permanent loss of sight. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger means loss by being permanently, physically, entirely severed. Voya does not pay a benefit for loss of use of the hand or foot or thumb and index finger.

Accidental Death & Dismemberment Exclusions

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

* Suicide or intentionally self-inflicted injury, while sane or insane.
* Physical or mental illness.
* Bacterial infection or bacterial poisoning. Exception: Infection from a cut or wound caused by an accident.
* Riding in or descending from an aircraft as a pilot or crew member.
* Any armed conflict, whether declared as war or not, involving any country or government.

* Injury suffered while in the military service for any country or government.
* Injury which occurs when you commit or attempt to commit a felony.
* Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

Voya does not pay benefits for loss sustained or contracted in consequence of your being under the influence of any controlled substance unless administered on the advice of a doctor.

General Provisions

Life Insurance Assignment

You can change the owner of your Life Insurance under the Group Policy by sending Voya written notice. This change is an absolute assignment. You cannot make an absolute assignment to the Policyholder or the Participating Employer. You transfer all your rights and duties as owner to the new owner. The new owner can then make any change the Group Policy allows. A request for an absolute assignment –

- does not change the insurance or the beneficiary.
- applies only if Voya receives your notice.
- takes effect from the date signed.
- does not affect any payment Voya makes or action Voya takes before receiving your notice.

A collateral assignment is not allowed.

Voya assumes no responsibility for the validity of any assignment. You are responsible to see that the assignment is legal in your state and that it accomplishes the goals that you intend.

Legal Action

Legal action may not be taken to receive benefits until 60 days after the date proof of loss is submitted according to the requirements of the Group Policy. Legal action must be taken within 3 years after the date proof of loss must be submitted. If the Policyholder's state requires longer time limits, Voya will comply with the state's time limits.

Exam and Autopsy

For AD&D Insurance, when reasonably necessary, Voya may have you examined while a claim is pending under the Group Policy. Voya pays for the initial exam. Voya may have an autopsy made if you die, if not forbidden by state law.

Incontestability

Your and your dependent's insurance has a contestable period starting with the effective date of your insurance and continuing for 2 years while you are living. During that 2 years, Voya can contest the validity of your and your dependent's insurance because of inaccurate or false information received relating to you and your insured dependent's insurability. Only statements that are in writing and signed by you or your insured dependent can be used to contest the insurance.

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 Voya 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 Voya 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 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 C are described in this section. For the procedures applicable 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), Kaiser HMO, 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.

Any retroactive cancelation or discontinuance of health or disability benefits (except if due to failure to pay a required contribution) will be considered an adverse benefit determination.

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

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 Codes (the diagnosis code)
- 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 C 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 (including those for mental health and/or substance abuse treatment) should be submitted to
Anthem Blue Cross Utilization Review Department by Phone at: (800) 274-7767

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 Benefits, Disability claims, 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 C Benefits

The claims procedures for Direct Pay Medical Plan C 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 114). 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**

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 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 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 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 Claim" 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.

Disability Claims

A Disability Claim must be submitted to the Trust Fund Office within 90 days after the date of the onset of the disability. To ensure that the persons involved with adjudicating disability claims and disability appeals (such as claim adjudicators and medical or vocational experts) act independently and impartially, decisions regarding hiring, compensation, promotion, termination or retention or other similar matters with respect to those individuals, will not be made based upon the likelihood that the individual will support the denial of benefits. The Fund will make a decision on the Disability Claim and notify the Eligible Individual of the decision within 45 days after receipt of the Claim by the Trust Fund Office. If the Fund requires an extension of time due to matters beyond the control of the Plan, the Trust Fund Office will notify Eligible Individual of the reason for the delay and the date by which the Fund expects to render a decision. This notification will occur before the expiration of the initial 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

A decision will be made within 30 days of the time the Fund notifies the Eligible Individual of the delay. The period for making a decision may be delayed an additional 30 days, provided the Fund notifies the Eligible Individual, prior to the expiration of the first 30-day extension period, of the circumstances requiring the extension and the date the Fund expects to render a decision.

If an extension is needed because the Fund needs additional information from the Eligible Individual, the extension notice will specify the information needed. If the information is not provided within the 45-day period, the Claim will be denied. During the 45-day period in which the Eligible Individual is allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from the date of the notification; or (2) the date the Eligible Individual responds to the request. Once the Eligible Individual responds to the Plan's request for the information, the Eligible Individual will be notified of the Plan's decision on the Claim within 30 days.

For Disability Claims, the Fund reserves the right to have a Physician examine the claimant (at the Plan's expense) as often as is reasonable while a claim for benefits is pending.

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.

Notice of Decision Disability Claim

The Eligible Individual will be provided with written notice of the initial benefit determination. If the determination is an adverse benefit determination, the notice will include:

(a) A discussion of the decision, including the basis for disagreeing with or not following:
   1. The views of a treating physician or vocational professional who evaluated the claimant;
   2. The views of medical or vocational experts obtained by the plan, and
   3. Any disability determination by the Social Security Administration.

(b) If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;

(c) Any plan internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim or a statement that such internal rules do not exist;

(d) A statement when the claim is denied that the claimant is entitled to receive relevant documents upon request; and

(e) If a Participant's address is in a county where ten percent or more of the population residing in the county is literate only in the same non-English language, then the Plan shall include in the notice of appeal determination a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. The language services provided by the Plan shall include (i) oral language services (such as a telephone customer assistance hotline) in any applicable non-English language and assistance with filing claims and appeals in any applicable non-English language; and (ii) upon request, a notice in any applicable non-English language.

Life Insurance and AD&D Claim

When Voya receives a notice of claim, forms will be sent to you for providing Voya proof of loss. Voya will send these forms within 15 days after receiving a notice of claim. If Voya 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 Voya 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.

Voya 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 Voya 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.

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 (60 days for a disability claim 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
Pre-Service Claim:	Call Anthem Blue Cross at (800) 274-7767
Post Service Claim:	Submit to the Trust Fund Office.
Concurrent Claim:	Send to either Anthem Blue Cross or the Trust Fund Office, depending on which organization made the adverse determination.
Burial Benefit Claim:	Submit to the Trust Fund Office.
Disability Claim:	Call the Trust Fund Office at (800) 635-3105

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.

For Disability Claims, you will be provided automatically and free of charge, with any new or additional evidence and/or additional rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence/rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of appeal is required to be provided) to give claimant a reasonable opportunity to respond prior to that date. If the Plan receives new or additional evidence or rationale so late in the disability claim filing or disability claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

Urgent Care Claim Appeals

Urgent Care Claim appeals should be submitted to Anthem Blue Cross. Your appeal will be reviewed by a different person at Anthem Blue Cross 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.

If the decision on review is not furnished to the Eligible Individual within the time specified above, your claim shall be deemed denied upon review. You will be free to bring an action upon your claim as outlined below.

For disability appeals, administrative procedures will be deemed to be exhausted if the Plan complies with the claims and appeals procedures herein or if:

- The plan's violation of the claims and appeals procedures was de minimis and did not cause, and is not likely to cause, prejudice or harm to the claimant so long as the plan demonstrates that the violation was for good cause or due to matters beyond the control of the plan and that the violation occurred in the context of an ongoing, good faith exchange of information with the claimant;

- This exception is not available if the violation is part of a pattern or practice of violations;

The plan must provide a written explanation of the violation within 10 days of receipt of any request from a Participant for an explanation of the violation.

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).

For Disability appeals:

* A discussion of the decision, including the basis for disagreeing with or not following:

  a) The view of a treating physician or vocational professional who evaluated the claimant;

  b) The views of medical or vocational experts obtained by the plan, and

  c) Any disability determination by the Social Security Administration.

* If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;

* Any plan internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim or a statement that such internal rules do not exist;

* A statement when the claim is denied that the claimant is entitled to receive relevant documents upon written request; and to respond to new information by presenting written evidence and testimony.

* A description of any applicable contractual limitations period and its expiration date; and

* If a Participant's address is in a county where ten percent or more of the population residing in the county is literate only in the same non-English language, then the Plan shall include in the notice of appeal determination a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. The language services provided by the Plan shall include (i) oral language services (such as a telephone customer assistance hotline) in any applicable non-English language and assistance with filing claims and appeals in any applicable non-English language; and (ii) upon request, a notice in any applicable non-English language.

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 (all administrative procedures have been exhausted for every

issue deemed relevant by you), 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.

No lawsuit may be started more than three years after the end of the year in which services were provided, or, if the claim is for disability benefits, more than three years after the start of the disability.

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.

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 is denied and your claim involves a rescission of coverage, determination of medical necessity, or a determination of experimental or investigational, 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, in the above section. 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).

Elimination of Conflict of Interest

To ensure that the persons involved with adjudicating claims and appeals (such as claim adjudicators and medical experts) act independently and impartially, decisions related to those persons' employment status (such as decisions related to hiring, compensation, promotion, termination or retention), will not be made on the basis of whether that person is likely to support a denial of benefits.

Assignment Rules

The Automotive Industries Welfare Fund is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. As a participant covered under the self-funded ERISA Plan C or certain eligibility determinations for Kaiser HMO coverage, you are guaranteed certain rights to appeal claim decisions that you don't agree with. If you are covered under the Kaiser HMO, you should refer to your EOC for your appeal rights under these benefits (unless your appeal is regarding eligibility for benefits which would be handled by the Fund).

When you go to see a healthcare provider, sometimes a provider may ask you to sign a form stating that any benefit payments for the services will be sent directly to the provider (rather than being paid to you). This is known as an "Assignment of Benefits." Please note that any assignment of benefits or direction to pay a provider does not assign your rights to file an appeal or lawsuit under ERISA to the provider, or in any way make the provider a plan beneficiary for purposes of ERISA. **This means that a provider is not able to file and/or pursue a claim appeal or file a lawsuit on your behalf by virtue of you signing a form instructing this Plan to pay your benefits directly to your provider.**

The Plan prohibits and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan Participant, a Participant's dependent or creditor of the Plan Participant without the express written permission of the Plan; however, a Plan Participant may direct that benefits due him/her, be paid to a healthcare provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan, and in no way shall be construed or interpreted as a waiver on the Plan's prohibition on assignments. The Plans are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

Coordination of Benefits (COB) and Subrogation

Benefits under the Automotive Industries Welfare Fund are designed to help meet the Allowed Charges 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 non-duplication 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.

* For a dependent child who has coverage under either or both parents' plans and also has his/her own coverage as a dependent under a Spouse's plan, covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in the longer/shorter length of coverage rule and if the length of coverage is the same, then the birthday rule applies between the dependent child's parent's coverage and the dependent's self or spouse dependent spouse's coverage.

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.

Coordination With Government and Other Programs

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

B. **TRICARE**: If a Dependent is covered by both this Plan and TRICARE, that provides health care services to Uniformed Service members, retirees and their families worldwide, this Plan pays first and TRICARE pays second. For an employee called to active duty for more than 30 days who is covered by both TRICARE and this Plan, TRICARE is primary and this Plan is secondary for active members of the armed services only. If an eligible individual under this Plan receives services in a Military Medical Hospital or Facility on account of a military service-related illness or injury, benefits are not payable by this Plan.

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

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

Acts of Third Parties

The Direct Pay Medical Plan C 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. Any eligible individual shall immediately notify the Plan if he or she is involved in or suffers an accident or injury for which a third party may be liable. Such eligible individual shall again notify the Plan if he or she pursues a claim to recover damages or other relief for which the Plan may make payments on the eligible individual's behalf and provide updates every 12 months thereafter, whenever a settlement is proposed and whenever requested by the Plan.
4. 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, or fails to submit to the Plan within one (1) year from the date of injury, 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.
5. 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.
6. 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.
7. 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 impair, release, discharge or 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.
8. 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 and distribution of any payments, in writing, as one which is not unreasonable from the standpoint of the Plan.
9. 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 Health Services & Benefit Administrators. The Administrative Office of the Fund is located at:

Automotive Industries Welfare Fund
4160 Dublin Blvd., Suite 400
Dublin, CA 94568-7756
Phone (800) 635-3105
Fax (925) 588-7121

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 94-6078226. The Plan Number is 501.

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

Saltzman & Johnson Law Corporation
1141 Harbor Bay Parkway, Suite 100
Alameda, CA 94502

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

John DiBernardo
SSA Terminals, LLC
14451 Cool Valley Ranch Road
Valley Center, CA 95082

Thomas A. Dillon, Chairman
California Metal Trades Association
851 Burlway Road, Suite 302
Burlingame, CA 94010

Ryan Thibodeau
UPS North CA District
8475 Pardee Drive
Oakland, CA 94621

Labor Trustees

Jim Beno, Secretary
IAM & AW District Lodge 190
8201 Capwell Drive
Oakland, CA 94621

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

Stephen Mack
International Teamsters Union
1601 Lake Chabot Terrace
San Leandro, CA 94577

Rich Morales
Local Union 1176
2020 Williams Street, Suite A1
San Leandro, CA 94577

Jim Schwantz
District Lodge 190
2102 Almaden Rd., Suite 105
San Jose, CA 95125

The Names and Addresses of all Health Care Issuers for the Medical Plan and Life Insurance 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 C.

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

Provides insured Employee Assistance benefits

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

Provides pre-paid medical and prescription drug benefits.

Voya

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 Fund 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 Fund and described in this Summary Plan Description are

Indemnity Medical Plan, Prescription Drug benefits; Mental Health and Substance Abuse benefits, Burial benefits, Dental PPO Plan, Vision benefits, and Life Insurance. Information regarding fully insured benefit options (such as the pre-paid Dental plan options) is provided in the Evidence of Coverage provided by the insurer.

Non-Assignment

The Plan and the Plan Sponsor categorically prohibit and will not accept in any circumstance any assignment or attempt to assign any benefits claims, right to coverage, or any other type of claims, regardless of the nature of such claims and any attempt to do so will be void and will not apply. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person, including the Plan Participant, a Participant's dependent or creditor of the Plan Participant without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due him/her, be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered.

The payment of benefits to a healthcare provider shall be done solely as a convenience and does not constitute an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, is not an assignment of any legal or equitable right to institute any court proceeding against the Plan or the Plan Sponsor, and in no way shall be construed or interpreted as a waiver on the Plan's and Plan Sponsor's prohibition on assignments. The Plan and Plan Sponsor are not responsible for paying healthcare provider invoices that are balance billed to a Plan Participant.

Statement of ERISA Rights Under Employee Retirement Income Security Act of 1974

As a Participant in the Automotive Industries Welfare Fund you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Employees 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 Employees, 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 Employees 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.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the Health Insurance Marketplace (the Marketplace helps people without health coverage find and enroll in a health plan, for California residents see: www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov).

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

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.

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 Fund. 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 Fund 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 child are all covered by the Plan, and the 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.

For Monthly Payments, What if the Full Cobra Premium Payment is not Made When Due?

If the Administrative Office receives a COBRA premium payment that is not for the full amount due, they will determine if the COBRA premium payment is short by an amount that is significant or not. A premium payment will be considered to be **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required COBRA premium payment.

If there is a significant shortfall, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

If there is not a significant shortfall, the Administrative Office will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.

- If the shortfall is paid in the 30-day time period, then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period, then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.

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.
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.

Conversion Privilege for Medical Coverage

At the end of the COBRA Continuation Coverage period, if you are enrolled in Kaiser, 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 Kaiser 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 Kaiser 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 Act of 2002 created a tax credit (called the Health Coverage Tax Credit or HCTC) 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). Eligible individuals can either take a tax credit or get advance payment of 72.5% of premiums paid for qualified health insurance including COBRA. While the HCTC expired on January 1, 2014, it was reinstated to be effective for coverage periods through 2019. For more information, visit, www.irs.gov/HCTC.

Post-COBRA Coverage California COBRA Law

The following provision applies **only** to Kaiser enrollees.

If you are a COBRA participant enrolled in Kaiser coverage, California law has a provision that affects the length of time you may continue coverage. This law only applies to Kaiser 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 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 and not through the Trust Fund Office.

Check your Kaiser 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 Kaiser'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 Death Benefits following the death of the Employee who is covered medical benefit under Medical Plan C .

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.

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

- **"Routine costs**" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a participant or beneficiary who is not enrolled in a clinical trial. However, the plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or drugs being studied as part of the approved clinical trial; (2) items, devices, services and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded (like a trial funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS)); (2) conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.
- For individuals who will participate in a clinical trial, **preauthorization is required** in order to notify the Plan that routine costs, services and supplies may be incurred by the individual during their participation in the clinical trial.
- The plan may require that an eligible individual use a PPO provider as long as the provider will accept the patient. This plan is only required to cover Non-PPO provider costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

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 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, effected 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;
- Allowed Charges 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. The Plan will provide benefits for Medically Necessary covered services performed by licensed or certified health professionals including, but not limited to, any of the following individuals who is licensed and practices within the scope of the license under applicable state law.

- 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. If there is any conflict between the benefits described in this Summary and the Evidence of Coverage from Kaiser, **the Evidence of Coverage will apply**.

BENEFIT	KAISER PERMANENTE
Office Visit	100% after $20/visit
Percentage Payable	100% after applicable copay
Calendar Year Deductible	$1,000 Individual/$2,000 Family
Out of Pocket Max	$2,000 Individual/$4,000 Family
Lifetime Maximum	None
Inpatient Hospital	80% after Deductible
Outpatient Surgery	80% after Deductible
Emergency Room	80% after Deductible
Skilled Nursing Facility Care	80% after Deductible 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	$10 per encounter after deductible
Physical Therapy	$20 per visit after deductible
Preventive Care	100%
Alcohol/Substance Abuse	Inpatient detox: 80% after Deductible Outpatient: $20 individual visit / 20% coinsurance up to $5 copay for other outpatient services
Mental Health	Inpatient: 80% after Deductible Outpatient: $20 copay/visit; 80% after Deductible for other outpatient services
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** (no deductible) **Retail Pharmacy**: Generic: $10 copay for 30 day supply Brand Name: $30 copay for 30 day supply **Mail Order:** Mail delivery from a Kaiser Permanente pharmacy available for refill prescriptions only. Generic: $20 copay for 100 day supply Brand Name: $60 copay 100 day supply
Chiropractic Care	Not Covered