SOUTH BAY HOTEL EMPLOYEES & RESTAURANT EMPLOYEES WELFARE FUND

SUMMARY PLAN DESCRIPTION 2020

UNITEHERE!

South Bay Hotel Employees, Restaurant Employees Trust Funds

Physical Address: 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 • Mailing Address: PO Box 34203, Seattle, WA 98124
Phone: (800) 544-5085 • Fax: (206) 505-9727 • Website: www.southbayheretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

November 17, 2021

TO: All Eligible Participants of the South Bay Hotel Employees, Restaurant Employees Welfare Fund

RE: Extension of Temporary Change in Eligibility Hour Requirement Gene-based, Cellular and Other Innovative Therapies (GCIT) - Effective January 1, 2022

This is a Summary of Material Modification describing changes to your health plan adopted by the Board of Trustees. Please be sure that you and your family read this notice carefully and keep it with your benefit booklet for future reference.

Extension of Temporary Change in Eligibility Hour Requirement

In their continuing effort to help Participants during the Coronavirus pandemic, the Union and Employer trustees of your health care plan have agreed to extend the lower hours requirement to obtain coverage through December 31, 2022 (October hours for December coverage). 80 hours per month are required to maintain one month of coverage.

Gene-based, Cellular and Other Innovative Therapies (GCIT)

Effective January 1, 2022, Gene-based, Cellular and Other Innovative therapies (GCIT) are covered only if provided by a participating provider and those who are manufacturer approved to administer the drugs. No benefits are provided for out-of-network providers.

GCIT products are FDA-approved therapies that are intended to treat or cure previously untreatable, often fatal, conditions. GCIT covered services include:

- Cellular immunotherapies.
- Genetically modified oncolytic viral therapy.
- Other types of cells and tissues from and for use by the same person (autologous) and cells and tissues from one person for use by another person (allogenic) for certain therapeutic conditions.
- All human gene-based therapy that seeks to change the usual function of a gene or alter the biologic properties of living cells for therapeutic use. Examples include therapies using:
  - Luxturna® (Voretigene neparvovec)
  - Zolgensma® (Onasemnogene abeparvovec-xioi)
  - Spinraza® (Nusinersen)
- Products derived from gene editing technologies, including CRISPR-Cas9.
- Oligonucleotide-based therapies. Examples include:
  - Antisense. An example is Spinraza.
  - siRNA.
  - mRNA.
  - microRNA therapies.

Travel and Lodging

Since travel may be required for a member to utilize the provider most appropriate for their type of GCIT service, the following are reimbursable expenses when a GCIT provider is used:

- Lodging Expenses
  - The benefit payable for lodging expenses is up to $50.00 per person for patient and one companion, $100.00 total per night
- Eligible Modes of Transportation
  - Coach Class airfare
  - Taxi
  - Bus
  - Train
  - Ferry
  - Shuttle
- Maximum Reimbursement for Travel & Lodging Expenses
  - The maximum reimbursement for all travel and lodging expenses is $10,000.00 per episode of care.

Non-Reimbursed/Non-Covered Expenses:

- Alcohol/tobacco
- Car rental
- Entertainment (e.g., movies, visits to museums, additional mileage for sightseeing, etc.)
- Expenses for persons other than the patient and his/her designated support person
- Gas
- Meals
- Personal care items (e.g., shampoo, deodorant, etc.)
- Souvenirs (e.g., t-shirts, sweatshirts, toys, etc.)
- Telephone calls and hotel room service
- Private Transportation
  - If the patient decides to drive, the Plan will reimburse the member for mileage per IRS guidelines. The Plan will also reimburse parking and tolls when receipts are provided except for expenses related to entertainment or that are otherwise personal in nature.

Aetna designates facilities to provide GCIT services or procedures. GCIT physicians, hospitals and other providers are GCIT-designated facilities/providers for Aetna. Participating Providers in California are:

- Children's Hospital Los Angeles, Los Angeles
- Ronald Reagan UCLA Medical Center, Los Angeles

Important Note:
Members must get GCIT **covered services** from the GCIT-designated facility/**provider.** If there are no GCIT-designated facilities/**providers** assigned in the member's network, it is important that the member contacts Aetna so they can help determine if there are other facilities that may meet the member's needs. If the member does not get GCIT services at the facility/**provider** Aetna designates, they will not be covered services.

Board of Trustees
South Bay Hotel Employees, Restaurant Employees Welfare Fund

This Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits. Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 206-441-7574, option 0 or toll free at 800-331-6158, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Important Reminder - You must advise the Administration Office of any changes in your basic demographic data, including changes in your name, marital status, dependents, other insurance coverage available, designated beneficiary, home address, email address and telephone number. Provide information changes by completing and sending a new Enrollment Form to the Administration Office. If you have a change in dependents, divorce requires a complete filed copy of your divorce decree along with any accompanying court orders including the parenting plan. Marriage requires a copy of your marriage certificate, the parenting plan for stepchildren and their birth certificates.

Failure to update your information on file may interfere with our ability to process your benefits and provide timely communication of important Plan information.

South Bay Hotel Employees, Restaurant Employees Trust Funds

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Phone (800) 544-5085 • Fax (206) 441-9110 • Website www.southbayheretrust.com

Administered by
Welfare & Pension Administration Service, Inc.

April 13, 2020

TO: All Participants and Beneficiaries
South Bay Hotel Employees, Restaurant Employees Welfare Fund

RE: Response to COVID-19 Outbreak

This is a Summary of Material Modifications ("SMM") describing changes to your Summary Plan Description. Please read this SMM carefully and keep it with your Summary Plan Description and other SMMS.

The following changes to the South Bay Hotel Employees & Restaurant Employees Welfare Fund are **effective immediately**.

Self-Insured Program/Aetna PPO Plans

- **COVID-19 Testing:** The Plan is waiving cost sharing (deductibles, copayments and coinsurance) for COVID-19 testing that is administered consistent with Centers for Disease Control and Prevention guidelines. The waiver applies both in-network and out-of-network and applies to the cost of the test and to the office visit and other provider charges related to the testing. Any prior authorization requirement for testing of COVID-19 also is waived. If a covered individual is diagnosed with COVID-19, all treatment (including but not limited to hospital, transportation and pharmacy services) will be covered in accordance with the terms and conditions set forth in the Summary Plan Description (SPD). Any deductible, copay or coinsurance will apply to treatment.

- **COVID-19 Treatment:** Any prior authorization requirement for treatment of COVID-19 is waived. (The Plan's terms are otherwise unchanged with respect to treatment of COVID-19.)

- **Early Prescription Refills:** The Plan is allowing a one-time early refill on 30-day supplies of maintenance drugs to help ensure individuals have an adequate supply in advance of a potential quarantine. The early refill allowance does not apply to certain controlled substances. If you have questions, please contact MaxorPlus Customer Service at 800-687-0707.

- **Teladoc: Effective April 1, 2020,** the Plan is providing 24/7 telehealth (virtual or telephonic) services through Teladoc. Claims are subject to the Plan's benefit limits. Enclosed is a flyer with Teladoc information.

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Kaiser Permanente Program: Cost sharing (deductibles, copayments and coinsurance) will be reduced to zero ($0.00) for medically necessary screening and testing for COVID-19, including the visit, associated lab testing, and radiology services, that is provided in a Kaiser hospital, emergency or urgent care setting, or medical office. This cost sharing reduction applies to all Kaiser and Kaiser-participating providers. If a covered individual is diagnosed with COVID-19, all treatment (including but not limited to hospital, transportation and pharmacy services) will be covered in accordance with the terms and conditions set forth in the coverage document. Kaiser encourages participants who are able to use telehealth/e-visits to do so. Enclosed is a flyer with information about Kaiser's telehealth process.

If you have any questions regarding this notice, please contact the Trust Office at 800-544-5085.

This Plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted.

Being a grandfathered health plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 800-544-5085, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Board of Trustees
South Bay Hotel Employees, Restaurant Employees Welfare Fund

Enclosures

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S:\Mailings\Individual Trust Fund Mailings (SMM, Benefit Changes, etc.)\F22-00\F22-02 - Mailing - 2020 - 04.13 - SMM - COVID19.docx

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What you need to know about **coronavirus**

made available through aetna™

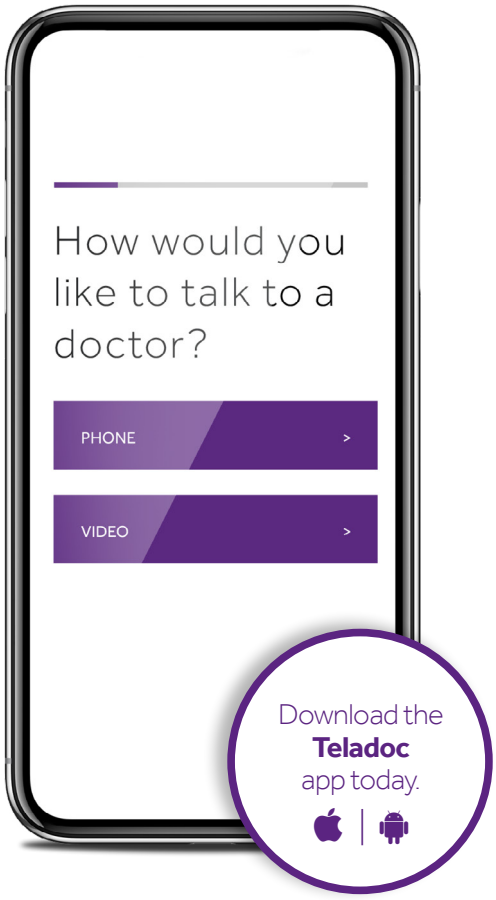
TELADOC®

Coronavirus (2019-nCoV) is a respiratory illness caused by a virus that was first identified in China. It is highly contagious and includes symptoms like fever, cough, and shortness of breath. The risk in the U.S. is currently low, but knowing how to protect yourself is key. Here are three tips:

1. **Keep it clean**
   Clean your hands with soap and water for 20 seconds after touching surfaces in public areas, and especially if you are around someone who isn't feeling well. Also, clean and disinfect frequently touched objects.

2. **Avoid contact with sick people**
   Avoid close contact with people who are sick and avoid traveling to locations where there are outbreaks of the coronavirus. And if you get sick, stay home to avoid spreading the virus to others.

3. **Contact Teladoc**
   There is no cure for coronavirus, but if you have symptoms of the virus, contact Teladoc and our doctors can evaluate your risk and help with next steps when necessary.



Talk to a doctor 24/7

Visit Teladoc.com/Aetna | Call 1-800-835-2362

Download the app — Download on the App Store | GET IT ON Google Play

COVID-19:
Cómo puede ayudar Aetna

aetna™ | TELADOC®

1 ¿Cómo puedo mantenerme protegido?
Lávese las manos y respete el distanciamiento social. Para ayudar a reducir el riesgo de una infección, lávese las manos, no se toque la cara y evite estar en contacto con personas enfermas.

2 ¿Dónde puedo recibir atención médica?
Los miembros que tienen un médico, primero deben llamar al profesional. Los miembros que tienen dudas porque pueden haber estado expuestos a la COVID-19 o tienen síntomas de la enfermedad, deben llamar a su médico de inmediato. Su médico determinará si es necesario hacerse una prueba de diagnóstico.

Los miembros que no tienen médico o que no pueden comunicarse con su médico, pueden usar Teladoc. Nuestros médicos están disponibles las 24 horas del día, todos los días, por teléfono o por video y pueden responder preguntas sobre el virus, evaluar el riesgo y brindar apoyo para ayudar a aliviar los síntomas. Tenga en cuenta que Teladoc no puede diagnosticar COVID-19 ni hacer una prueba para detectarlo.

En respuesta al brote de COVID-19, entre el 6 de marzo de 2020 y el 4 de junio de 2020, los miembros elegibles* de Aetna no pagarán el costo de todas las consultas médicas generales, las consultas a profesionales de la salud mental ni a dermatólogos que se hagan través de Teladoc.

Debido a la COVID-19, utilizar Teladoc se ha vuelto más necesario que nunca, y es posible que el tiempo de espera se prolongue. Le pedimos que sepa comprender y tenga paciencia.

3 ¿Qué sucede si estoy muy enfermo?
Consulte con un médico (o vaya la sala de urgencias), pero asegúrese de llamar antes de ir.

Última actualización: 16 de abril de 2020

Consulte a un médico las 24 horas, todos los días.

Llame al 1-855-TELADOC (835-2362) | Visite Teladoc.com/Aetna
Descargue la aplicación Aetna Health

*** A fin de confirmar si es elegible para no pagar el costo compartido de miembro, inicie sesión en su cuenta de Teladoc a través de la web o de la aplicación y solicite una consulta para confirmar el costo.**

** Términos y condiciones: bit.ly/2nlJFYG Política de privacidad: aetna.com/legal-notices/privacy.html. Si envía un mensaje de texto al 90156, usted otorga su consentimiento para recibir un mensaje de texto comercial que emite automáticamente Aetna con un enlace para descargar la aplicación Aetna HealthSM. No es necesario que otorgue su consentimiento para descargar la aplicación. También puede descargarla desde las tiendas App Store o Google Play.

Your care, your way

Connect to care anytime, anywhere

Get the care you need the way you want it. No matter which option you choose, your providers can see your health history, update your medical record, and give you personalized care that fits your life.

Choose where, when, and how you get care

Not sure where to go for care? Visit **kp.org/getcare** for more information.

24/7 care advice

Get medical advice and care guidance in the moment from a Kaiser Permanente provider.

In-person visit

Same-day appointments are often available. Sign on to **kp.org** anytime, or call us to schedule a visit.

Email

Message your doctor's office with nonurgent questions anytime. Sign on to **kp.org** or use our mobile app.[2]

Phone appointment

Save yourself a trip to the doctor's office for minor conditions or follow-up care.[2,3]

Video visit

Meet face-to-face online with a doctor on your computer, smartphone, or tablet for minor conditions or follow-up care.[2,3]

Need care now? Know before you go.

Urgent care

An urgent care need is one that requires prompt medical attention, usually within 24 or 48 hours, but is not an emergency medical condition. This can include minor injuries, backaches, earaches, sore throats, coughs, upper-respiratory symptoms, and frequent urination or a burning sensation when urinating.

Visit **kp.org/getcare** to find the urgent care location nearest you.

Emergency care

A medical or psychiatric condition that requires immediate medical attention to prevent serious jeopardy to your health.[1] Examples include:

- Chest pain or pressure
- Severe stomach pain that comes on suddenly
- Decrease in or loss of consciousness
- Severe shortness of breath

If you think you have a medical or psychiatric emergency, call **911** or go to the nearest hospital.

[1]If you reasonably believe you have an emergency medical condition, call 911 or go to the nearest emergency department. An emergency medical condition is a medical or psychiatric condition that requires immediate medical attention to prevent serious jeopardy to your health. For the complete definition of an emergency medical condition, please refer to your *Evidence of Coverage*.

[2]These features are available when you receive care at Kaiser Permanente facilities.

[3]When appropriate and where available. You must be 18 years or older to schedule.

Please recycle. 60739309 October 2017

KAISER PERMANENTE®

Su atención, a su manera

Conéctese con la atención a cualquier hora y en cualquier lugar

Obtenga la atención médica que necesita, como usted la desea. Sin importar la opción que elija, sus proveedores pueden ver sus antecedentes de salud, actualizar su historia clínica y darle el cuidado personalizado que se adapte a su vida.

Elija dónde, cuándo y cómo recibir atención

¿No está seguro de dónde solicitar atención? Visite **kp.org/getcare** (haga clic en "Español") para obtener más información.

Consejos de atención médica las 24 horas al día, los 7 días a la semana.

Obtenga al momento consejos médicos y orientación sobre el cuidado de la salud de un proveedor de Kaiser Permanente.

Consulta en persona

Por lo general, hay citas disponibles para consultas el mismo día. Ingrese a **kp.org/espanol** en cualquier momento, o llámenos para programar una consulta.

Correo electrónico

Envíe un mensaje al consultorio de su médico con preguntas que no sean urgentes en cualquier momento. Ingrese a **kp.org/espanol** o use nuestra aplicación móvil.[2]

Cita por teléfono

Ahórrese un viaje al consultorio del médico para afecciones leves o la atención de seguimiento.[2,3]

Consulta por video

Comuníquese en línea directamente con un médico desde su computadora, teléfono inteligente o tableta para afecciones leves o atención de seguimiento.[2,3]

¿Necesita recibir atención médica en este momento? Infórmese.

Atención de urgencia

Una necesidad de atención de urgencia es cuando se requiere atención médica inmediata, por lo general, dentro de un plazo de 24 a 48 horas, pero no se trata de un problema médico de emergencia. Esto puede incluir lesiones leves, dolor de espalda, dolor de oídos, dolor de garganta, tos, síntomas en las vías respiratorias superiores, así como orinar con frecuencia o tener una sensación de ardor al orinar.

Visite **kp.org/getcare** (haga clic en "Español") para encontrar el centro de atención de urgencia más cercano a usted.

Atención de emergencia

Un problema médico o psiquiátrico que requiere atención médica inmediata para evitar un peligro grave para su salud.[1] Algunos ejemplos incluyen:

- Dolor o presión en el pecho
- Dolor de estómago grave que se presenta de manera repentina
- Disminución o pérdida del conocimiento
- Falta de aire grave

Si usted cree que tiene una emergencia médica o psiquiátrica, llame al **911** o acuda al hospital más cercano.

[1]Si cree, dentro de lo razonable, que tiene un problema médico de emergencia, llame al 911 o vaya al departamento de emergencias más cercano. Un problema médico de emergencia es un problema médico o psiquiátrico que requiere atención médica inmediata para evitar un peligro grave para su salud. Consulte la definición completa del término "problema médico de emergencia" en su *Evidencia de Cobertura (Evidence of Coverage)* u otros documentos de cobertura.

[2]Estos beneficios están disponibles cuando recibe atención en los centros de atención de Kaiser Permanente.

[3]Cuando corresponda y estén disponibles. Debe tener más de 18 años de edad para programar una cita.

Please recycle. 60935308 March 2018

KAISER PERMANENTE®

South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund

Summary Plan Description/Plan Document

<u>Describing:</u>
Self-Funded Medical Plan
Optional HMO Plans
PPO Dental Plan
HMO Dental Plan
Vision Plan
Life and Accidental Death & Dismemberment Plan,
Housing Benefit,
Child Care Program

Amended and restated effective April 1, 2020

TABLE OF CONTENTS

TO ALL ELIGIBLE PARTICIPANTS:

This booklet sets forth the provisions relating to eligibility and benefits for the self-funded Medical benefits provided to you and your eligible dependents as a result of Collective Bargaining. The booklet provides an overview of benefits about certain insured benefits such as the Vision Plan, Dental PPO, Dental HMO and Life and AD&D benefits. This document also contains information required by the Employee Retirement Income Security Act of 1974 (ERISA), the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), the Omnibus Budget Reconciliation Act of 1993 (OBRA), the Mental Health Parity Act (MHPA) as well as the Health Insurance Portability and Accountability Act (HIPAA) and other federal regulations.

The Trustees of the Trust Fund encourage you to study this material so you will be familiar with all aspects of your Health & Welfare Plan.

IMPORTANT NOTE:

- New eligibles have a choice of enrolling in either the Self-Funded or HMO Medical Plans. Enrollment in the DHMO Dental Plan will be required for the first 2 years of eligibility. Upon completion of the 2-year eligibility requirement, the PPO Dental Plan can be selected. The Plan you select will apply to you and to your eligible dependents.
- If a new employee does not make a choice within 30 days of their date of eligibility for benefits the employee will automatically be enrolled in this Self-Funded Medical and DHMO Dental Plan and cannot change Plans until the next annual Open Enrollment period for Medical (2 years enrollment for Dental), unless a Special Enrollment opportunity exists.

The benefits illustrated in this booklet are made possible by your Employer's contribution to the Trust Fund on your behalf.

Be sure to check the Employer Transmittal at your place of employment for the contribution amount being paid to the Trust Fund on your behalf. This is usually posted by the time clock. If at any time you do not find this information posted, please ask your employer and report it to the Administration Office.

NEITHER UNION REPRESENTATIVES NOR EMPLOYER REPRESENTATIVES ARE RESPONSIBLE FOR COLLECTION OF THESE CONTRIBUTIONS, NOR ARE THEY AUTHORIZED TO ANSWER QUESTIONS RELATED TO BENEFITS OF THE PLAN.

Waiver of Class, Collective and Representative Actions: By participating in the Plan, to the fullest extent permitted by law, whether in court, Participants waive any right to commence, be a party to in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy, and Participants agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

Only the full Board of Trustees is authorized to interpret the Plan of Benefits described in this booklet. No individual Trustee, union representative or employer representative is authorized to interpret this Plan on behalf of the Board or to act as an agent of the Board. The Trustees have authorized the Administration Office to respond in writing to written inquiries from plan participants. As a convenience to you, the staff of the Administration Office will provide oral answers and advice on an informal basis. However, no such oral communication is binding with the Board of Trustees.

BENEFITS MAY BE CHANGED DURING THE TERM OF THIS PLAN. THE REVISED BENEFITS (INCLUDING ANY REDUCTION OR ELIMINATION OF BENEFITS) APPLY FOR SERVICES OR SUPPLIES FURNISHED AFTER THE EFFECTIVE DATE OF CHANGE. THERE IS NO VESTED RIGHT TO RECEIVE ANY BENEFIT FROM THIS PLAN.

Please contact the Administration Office when you have any questions concerning your Plan benefits or eligibility:

WELFARE & PENSION ADMINISTRATION SERVICE, INC.
Telephone: (408) 321-9700 or (800) 544-5085

FOREIGN LANGUAGE NOTICE

This booklet contains a summary in English of your rights and benefits under the South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund. If you have any difficulty in understanding any part of this booklet, you may contact Welfare & Pension Administration Service, Inc., P.O. Box 34203, Seattle, WA 98124-1203, 408-321-9700 or 800-544-5085.

Aviso En Español

Este folleto contiene un resumen en ingles de sus derechos y beneficios bajo el South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede comunicarse con Welfare & Pension Administration Service, Inc., P.O. Box 34203, Seattle, WA 98124-1203, 408-321-9700 o 800-544-5085.

INTRODUCTION

WHAT THIS DOCUMENT TELLS YOU

This booklet (called the Summary Plan Description/Plan Rules) describes the eligibility rules along with the self-funded medical benefits of the South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund, hereafter referred to as the "Plan". This booklet highlights some of the insured benefits available to you such as the Dental PPO, Dental HMO, Vision Plan and Life and Accidental Death and Dismemberment (AD&D) benefits. Separate booklets/documents are available to describe these insured benefits as well as the HMO Medical Plan options.

The Plan described in this document is effective **April 1, 2020**, except for those provisions that specifically indicate other effective dates, and replaces all other Summary Plan Description/Plan rules previously provided to you.

This document will help you understand and use the benefits provided by the South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund. You should review it and share it with those members of your family who are or will be covered by the Plan. It will give all of you an understanding of the coverages provided; the procedures to follow in submitting claims and filing an appeal; and your responsibilities to provide necessary information to the Plan. Be sure to read the Exclusions and Definitions chapters. **Remember, not every expense you incur for health care is covered by the Plan.**

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

- **BENEFIT CHANGES:** The Trustees of the Trust Fund are committed to maintaining health care coverage for employees and their families at an affordable cost, however, because future conditions cannot be predicted, the Plan reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is changed (amended) from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information. The revised benefits, including any reduction or elimination of benefits, apply for services or supplies furnished after the effective date of the change. There is no vested right to receive any benefit from this Plan.
- **SELF-FUNDED BENEFITS:** The medical plan (including prescription drugs) benefits described in this booklet are self-funded and made possible by your employer's contributions to the Trust Fund on your behalf. The contributions to the Plan are held in a Trust. An independent Claims Administrator (referred to as the Administration Office) pays benefits out of Trust assets. The Administration Office's address and phone number are listed on the Quick Reference Chart in the front of this document.
- **INSURED BENEFITS**: The following benefit options are provided by various insurance companies under contract to the Trust Fund: the HMO health plan options, Dental PPO, Dental HMO plan, the Vision Plan, and Life and Accidental Death and Dismemberment (AD&D) benefits. The names of the companies who insure these benefits are listed on the Quick Reference Chart in this document. While this document may highlight certain provisions of these insured plans, you should refer to the documents provided to you by those insurance companies for complete information on your insured benefits.

IMPORTANCE OF TERMS

Certain terms used in this document, to describe the individuals eligible or covered for benefits, are important. These terms are defined in the Definition Article of this document and outlined below:

- **"Member"** is the term applied to an Active Employee or Retiree only.
- **"Participant"** refers to an eligible Active Employee, Retiree, Domestic Partner and eligible Dependents.
- **"Dependents"** refers only to an eligible Spouse, eligible Domestic Partner and eligible Dependent Children.

SUGGESTIONS FOR USING THIS DOCUMENT

This document provides detail about your Plan. We suggest that you pay particular attention to the following: Read through this **Introduction** and look at the **Table of Contents** that immediately precedes it. If you don't understand a term, look it up in the Definitions chapter. The **Table of Contents** provides you with an outline of the chapters. This document contains a **Quick Reference Chart** following this introductory text**.** This is a handy resource for the names, addresses and phone numbers of the key contacts for your benefits such as the Claims Administrator (also referred to in this document as the Administration Office).

- The **Eligibility chapter** outlines who is eligible for coverage and when coverage ends while the **COBRA chapter** discusses your options if coverage ends for you or a covered Dependent.

- Review the **Medical Expense, Schedule of Medical Benefits and Medical Exclusions chapters.** These describe your benefits in more detail. There are examples, charts and tables to help clarify key provisions and more technical details of the coverages.
- Review the **Medical Networks and Utilization Management chapters**. They describe how you can maximize Plan benefits by following the provisions explained in these chapters.
- Review the **Dental Expense, Schedule of Dental Benefits and Dental Exclusions** chapters for an explanation of the dental benefits of this Plan.
- Refer to the **General Provisions chapter** for information regarding your rights and information about ERISA, while the **Claim Filing and Appeal Information chapter** tells you what you must do to file a claim and how to seek review (appeal) if you are dissatisfied with a claims decision.
- The chapter on **Coordination of Benefits** discusses situations where you have coverage under more than one group health care plan, Medicare, another government plan, personal injury protection under mandatory no-fault automobile insurance coverage, workers' compensation, or where you can recover expenses from any other source.
- The **Definitions** chapter provides useful information on the meaning of certain technical, medical and legal terms that appear in the text of this document.

IMPORTANT NOTICE

Notifying the Plan: You or your Dependents must **promptly furnish** to the Administration Office information regarding change of name, address, marriage, divorce or legal separation, death of any covered family member, change in status of a Dependent Child, Medicare enrollment or disenrollment or the existence of other coverage. **Failure to do so may cause you or your Dependents to lose certain rights under the Plan.**

Answer to Your Questions: Neither union representatives nor employer representatives are responsible for collection of contributions to this Plan and they are not authorized to answer questions related to the benefits described in this Plan. Only the Board of Trustees is authorized to interpret the benefits of the Plan. No individual Trustee, union representative or employer representative is authorized to interpret this Plan on behalf of the Board of Trustees or to act as an agent of the Board. The Trustees have authorized the Administration Office to respond in writing to written inquiries from Plan participants. As a convenience to you, the staff of the Administration Office will provide oral answers and advice on an informal basis; however, no such oral communication is binding with the Board of Trustees.

QUICK REFERENCE CHART

FOR HELP OR INFORMATION: WHEN YOU NEED INFORMATION, PLEASE CHECK THIS DOCUMENT FIRST. IF YOU NEED FURTHER HELP, CALL THE PEOPLE LISTED IN THE FOLLOWING QUICK REFERENCE CHART

Information Needed	Whom to Contact
Claims Administrator (Administration Office) • Claim Forms (Medical) • Medical Claims and Appeals • Eligibility for Coverage • Plan Benefit Information • HIPAA Certificate of Creditable Coverage • Medicare Notice of Creditable Coverage	**Welfare & Pension Administration Service, Inc.** 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 *Submit claims to this address*: P.O. Box 34687, Seattle 98124-1687 *Submit general correspondence to this address*: P.O. Box 34203, Seattle, WA 98124-1203 • **Phone: (408) 321-9700 or (800) 544-5085** • Fax: (206) 441-9110 (for claims only) • Website: www.southbayheretrust.com

Trust Website
• Forms: medical, legal document and notices
• Plan Booklets: Health and Security, Legal Booklet
• Links to Health Plan Provider Networks, Union Membership benefits and other useful sites
• HIPAA Privacy Notice and Information
• Local Unions
• **"My Personal Benefit" Information contains**:
  • Personal Information: name, address, gender, birth date, marital status, etc.
  • Health Eligibility: eligibility in the current month and past 3 months
  • Hours/Contributions: statement showing the last 3 employers reporting hours and contribution to the Trust on your behalf
  • Dependent Enrollment information
	Website: www.southbayheretrust.com
	• There is a secure location on this website called "My Personal Benefits" that requires your personal identification number (PIN) and your social security number. For security reasons, you may not choose your own PIN, a PIN will be assigned to you.
	• To obtain a PIN, download a "PIN Request Form from the Trust website (listed above) or contact the Administration Office for a "PIN Request Form" and once completed, return this form to the Administration Office. Your PIN will be mailed to you.
	• Questions about the PIN contact the Administration Office: 1-800-544-5085.

PPO Network • Medical Network Provider Directory	**Aetna Choice POS II (Open Access)** 1-888-632-3862 www.aetna.com/individuals-families/find-a-doctor.html
Utilization Management (UM) Company • Precertification/preauthorization • Case Management • Appeals of UM decisions	**Aetna** 1-888-632-3862
Prescription Drug Plan • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy Service • Prescription Drug Information • Precertification (pre-approval) of Certain Drugs	**MaxorPlus LTD** • Retail Customer Service Phone: 1-800-687-0707 • Mail Order Customer Service Phone: 1-800-687-8629 • Mail Order Address: 416 S. Tyler, Amarillo, TX 79101 • Website: www.maxorplus.com
Dental Plans • Dental Network and Provider Directories • Dental Claims and Appeals	**MetLife Dental PPO and DHMO Plans** 1-800-942-0854 1-800-880-1800 Website: www.metlife.com/mybenefits

FOR HELP OR INFORMATION: WHEN YOU NEED INFORMATION, PLEASE CHECK THIS DOCUMENT FIRST. IF YOU NEED FURTHER HELP, CALL THE PEOPLE LISTED IN THE FOLLOWING QUICK REFERENCE CHART

Information Needed	Whom to Contact
Insured Vision Plan • Vision Network and Provider Directory • Vision Claims and Appeals	**Vision Service Plan (VSP)** P.O. Box 997100 Sacramento, CA 95899-7100 1-800-877-7195 www.vsp.com
COBRA Administrator • Information About COBRA Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments	**Welfare & Pension Administration Service, Inc.** 7525 SE 24th Street, Suite 200, Mercer Island, WA 98040 Mailing Address: P.O. Box 34203, Seattle, WA 98124-1203 **Phone: (408) 321-9700 or (800) 544-5085** Fax: (206) 505-9727
Plan Administrator/Board of Trustees • Level 2 Claim Appeals	**Board of Trustees for the South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund** P.O. Box 34687 Seattle, WA 98124-1687 www.southbayheretrust.com
HIPAA Privacy Official **HIPAA Security Official**	Privacy Official/Claims Manager Welfare & Pension Administration Service, Inc. P.O. Box 34203 Seattle, WA 98123-1203 Security Official/Claims Manager Welfare & Pension Administration Service, Inc. P.O. Box 34203 Seattle, WA 98123-1203 **Website: www.southbayheretrust.com**
Life and Accidental Death and Dismemberment (AD&D) Insurance Carrier	**Aetna Life Insurance Company** For questions contact the Claims Administrator at their phone number in the first row of this chart.
Housing Benefits	For questions contact the Claims Administrator at their phone number in the first row of this chart.

ELIGIBILITY

HOW AND WHEN COVERAGE BEGINS, IS MAINTAINED AND ENDS

WHO IS ELIGIBLE FOR COVERAGE AND START OF COVERAGE

These eligibility rules apply to the South Bay and Central Coast participants. Eligibility for benefits under this Plan is established under an Hour Bank system. This system is a procedure whereby the hours worked for a contributing employer to this Trust Fund are accumulated for credit to an employee's account. An employee may accumulate additional hours for eligibility to be used during period of low employment or layoff.

ENROLLMENT PROCEDURE

a. There are three opportunities to enroll for coverage under this Plan: Initial Enrollment, Special Enrollment, and Open Enrollment. These opportunities are described further in this chapter.

b. **Procedure to request enrollment:** Generally, an individual must call, fax, or walk into the Benefits Department (or their local union office) and indicate their desire to enroll themselves or a dependent in the Plan. (The address, phone number, and fax number for the Administration Office is listed on the Quick Reference Chart in the front of this document.) Note that the Open Enrollment procedure can differ from this process and if so, the procedure on how to enroll at this time will be announced by the Plan at the beginning of the Open Enrollment period.

c. Once enrollment is requested, the individual will be provided with the steps to enroll that include all of the following:

   1) submit a completed written enrollment form (which may be obtained from and submitted to the Administration Office or the local union office). See also the Domestic Partner provisions in this chapter for information on how to enroll a Domestic Partner; and

   2) provide proof of Dependent status (as requested), and

   3) pay any required contributions for coverage, and

   4) perform steps 1) through 3) above in a timely manner according to the timeframes noted under the Initial, Special and Open enrollment provisions of this Plan.

d. Proper enrollment is required for coverage under this Plan. A person who has not properly enrolled by completing the above noted steps, in a timely manner, has no right to any coverage for Plan benefits or services under this Plan.

e. This Plan **does not** administer a pre-existing condition limitation provision.

EMPLOYEE INITIAL ELIGIBILITY/ENROLLMENT

a. If an employee works 100 hours for two consecutive months and the employer makes the necessary contribution, the employee will become eligible for health insurance coverage on the first day of the fourth month.

b. A minimum of 22 hours must be worked each month to be eligible for self-payment. The balance up to 100 hours can be in any combination of hours worked and self-payment. Self-payments are due to the Administration Office no later than the 20th day of the following month or within 10 days of the receipt of the employer's report of hours, whichever is later (i.e. January self-pay hours must be paid by February 20th).

c. The amount of the self-payment is the number of hours needed times the total current contribution rate for health as established by the Trust Fund. If you worked the minimum 22 hours in a month you would be required to pay the difference between 22 and 100 hours. For example, 100 minus 22 equals 78 hours which is then multiplied times the current hourly contribution rate.

d. Because your employer may be late in making the required contributions to the Trust Fund, it is recommended that you **save your payroll stubs to verify hours worked**. These stubs can help prove to the Administration Office your eligibility for continued coverage. Eligibility will not be updated until employer contributions are received. If a participant wishes to pay additional hours to preserve a self-pay bank for future use, they are permitted to do so.

IMPORTANT NOTE:

a. New eligibles have a choice of enrolling in either the Self-Funded or HMO Medical Plans. Enrollment in the DHMO Dental Plan will be required for the first 2 years of eligibility. Upon completion of the 2-year eligibility requirement, the PPO Dental Plan can be selected. The Plan you select will apply to you and to your eligible dependents.

b. If a new employee does not make a choice within 30 days of their date of eligibility for benefits the employee will automatically be enrolled in this Self-Funded Medical and DHMO Dental Plan and cannot change Plans until the next annual Open Enrollment period for Medical (2 years enrollment for Dental), unless a Special Enrollment opportunity exists.

EMPLOYEE CONTINUATION OF COVERAGE

a. The following is required in order to continue coverage under this Plan: either 100 hours worked plus paid contributions, or a combination of 22 hours or more worked and self-payments to equal 100 hours.

b. **Lag Month:** To provide sufficient time for contributing employers' reports to be received and processed by the Administration Office, a lag month is used in determining active employee eligibility. Active employee coverage begins on the first day of the calendar month following the lag month. The lag month is the month between the hours worked and the month that the employee becomes eligible for coverage.

c. A **break in coverage** occurs whenever an employee does not work at least 22 hours in a month or does not make the necessary self-payments to continue eligibility. After an employee has established initial eligibility and a break in coverage occurs, the employee may requalify for coverage by working a minimum of 22 hours and self-paying the difference up to 100 hours within six months of any break in coverage. If a break in coverage occurs there will be a lag month between the hours worked and the month the employee becomes eligible for coverage.

d. If a **break in coverage exceeds six months**, the employee must requalify according to the Initial Eligibility provisions outlined above.

HOUR BANK ELIGIBILITY

a. Each participant will be able to establish his or her own Hour Bank, utilizing any hours accumulated in excess of the 100 hours required each month. An employee must be currently employed to use the Hour Bank for continuing eligibility. The maximum hour bank accumulation is 80-hours.

DEPENDENTS' ELIGIBILITY

a. Who Qualifies as a Dependent: Once an employee has satisfied the eligibility requirements for coverage under this Plan the following family members may qualify as eligible dependents:

1) the employee's **legal spouse or legally separated spouse**.
2) the employee's **domestic partner** (as defined in the Definitions chapter of this document).
3) the employee's **unmarried children who are under age 26** and dependent on the employee for support and permanently residing with the employee.
4) the employee's **handicapped child over age 26** who is mentally and/or physically handicapped and chiefly dependent on the employee for support and maintenance. The Plan may require proof of incapacity and dependency.
6) a child for whom the employee has a **Qualified Medical Child Support Order** (QMCSO).

b. Qualified Medical Child Support Order (QMCSO):

1) The Plan will comply with any medical child support order provided it is properly served and the Plan Administrator or its designee determines that the order is a qualified medical child support order under applicable federal law. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the plan recognize the child as a dependent even though the child may not meet the Plan's definition of dependent. A QMCSO usually results from a divorce or legal separation and typically:
   - Designates one parent to pay for a child's health plan coverage;
   - Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
   - Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
   - States the period for which the QMCSO applies.
2) An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any option that the Plan does not otherwise provide, or if it requires an employee who is not covered by the Plan to provide coverage for a Dependent Child, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.
3) Upon service with a medical child support order, the Administration Office will review the order under the procedures adopted by the Board of Trustees and determine within a reasonable time whether or not the order is a QMCSO. The determination that an order is not a QMCSO is subject to the appeals procedures described in the Claim Filing and Appeals Information chapter of this document. The Plan Administrator or its designee will notify the parents and each

child if an order is determined to be a QMCSO, and if the employee is covered by the Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child(ren).

4) **If the employee is already a Plan Participant**, the QMCSO may require the Plan to provide coverage for the employee's Dependent Child(ren) and to accept contributions for that coverage from a parent who is not a Plan participant. The Plan will accept a Special Enrollment of the Dependent Child(ren) specified by the QMCSO from either the employee or the custodial parent. Coverage of the Dependent Child(ren) will become effective as of the date the enrollment is received by the Plan and will be subject to all terms and provisions of the Plan as permitted by applicable law.
5) **If the employee is not a Plan Participant** when the QMCSO is received (but is otherwise eligible) and if the QMCSO orders the employee to provide coverage for the Dependent Child(ren) of the employee, the Plan will accept a Special Enrollment of the employee and the Dependent Child(ren) specified by the QMCSO. Coverage of the employee and the Dependent Child(ren) will become effective as of the first day of the fourth month following the date the enrollment is received by the Plan as permitted by applicable law.
6) No coverage will be provided for any Dependent Child under a QMCSO unless the applicable employee contributions for that Dependent Child's coverage are paid, and all of the Plan's requirements for coverage of that Dependent Child have been satisfied.
7) Coverage of a Dependent Child under a QMCSO will terminate when coverage of the employee-parent terminates for any reason, including failure to pay any required contributions, subject to the Dependent Child's right to elect COBRA Continuation Coverage if that right applies. For additional information regarding the procedures for administration of QMCSOs, contact the Administration Office and see also the Claim Filing and Appeal Information chapter of this document for payment of claims under QMCSOs.

c. Dependent Coverage:

1) Eligible employees must request the addition of a new dependent according to the procedures described above under Enrollment Procedure.
2) Employees may self-pay to add dependent coverage at a cost determined by the Board of Trustees. The dependent self-pay rate information is available by contacting the Administration Office at their phone number listed on the Quick Reference Chart in the front of this document. Self-payment amounts are subject to change based on annual review by the Board of Trustees.
3) Dependent self-payments are due no later than the 20th of the month following the month in which the employee's hours were worked.
4) Dependent coverage will become **effective on the later of**:
   a) the date the employee becomes eligible for coverage **or**
   b) the date the dependent becomes eligible for coverage and applies for coverage under this Plan (see the Enrollment procedure in this chapter) and pays any required contributions for coverage.
5) If an employee does not enroll all eligible dependents at the time the employee is initially eligible for coverage the employee cannot enroll an eligible dependent until the next annual Open Enrollment, unless there is a Special Enrollment opportunity.
6) If payment for dependent coverage stops during the year the dependent will lose eligibility and cannot be re-enrolled for coverage until the next annual Open Enrollment period, unless there is a Special Enrollment opportunity.
7) If you elect coverage for yourself, you are also eligible for the same health care coverage for your Eligible Dependents on the later of the day you become eligible for your own health care coverage or the day you acquire an Eligible Dependent, either by marriage, birth, adoption or placement for adoption, but only if you have submitted a completed written enrollment form which can be obtained from the Administration Office and if that health care coverage is in effect for you on that day and you provide the Plan's required proof of Dependent status and pay any required contribution for coverage of the dependent(s). A Dependent may not be enrolled for coverage unless the employee is also enrolled. Specific documentation to substantiate Dependent status may be required.

d) Proof of Dependent Status:

Specific documentation to substantiate Dependent status will be required by the Plan and may include proof of the same principal place of abode and any of the following:

1. **Marriage:** copy of the certified marriage certificate.
2. **Birth:** copy of the certified birth certificate.
3. **Adoption or placement for adoption**: court order paper signed by the judge.

4. **Foster Child:** a copy of the foster child placement papers from a qualified state agency and any proof of any state provided health coverage.
5. **Legal Guardianship:** a copy of your court-appointed legal guardianship documents and a copy of the certified birth certificate.
6. **Disabled Dependent Child:** Current written statement from the child's physician indicating the child's diagnoses that are the basis for the physician's assessment that the child is currently mentally or physically Handicapped (as that term is defined in this document) and is incapable of self-sustaining employment as a result of that handicap; and dependent chiefly on the employee and/or employee's spouse for support and maintenance. The Plan may require proof of initial and ongoing disability and that the child meets the Plan's definition of Dependent Child.
7. **Qualified Medical Child Support Order** (QMCSO): Valid QMCSO document or National Medical Support Notice.
8. **Domestic Partner**: Signed affidavit by the employee and domestic partner that they meet the requirements of this Plan's domestic partner eligibility using the Plan's "Statement of Domestic Partnership" form, state recognized and notarized Domestic Partner registration form.

e. Domestic Partners:

1. Domestic Partner coverage is available to eligible individuals, unless not permitted under a collective bargaining agreement. The Domestic Partner benefit is not subsidized by those employers whose collective bargaining agreements do not call for the domestic partner of an eligible employee to be treated as an eligible dependent of an eligible employee. To prevent any prohibited subsidization this benefit will provide only the Plan Years where the employer contributions under a collective bargaining agreement calling for this benefit matches contributions being paid under other applicable collective bargaining agreements plus any additional amounts of premium imposed by the Trust Fund for domestic partner coverage.
2. Individuals who qualify as a Domestic Partner, as that term is defined in the Definitions chapter of this Plan, may be eligible to enroll for coverage upon completion of the enrollment process. An eligible employee must submit a completed Domestic Partner form and notarized Declaration of Domestic Partnership document to commence the enrollment process. The enrollment forms are available from the Administration Office.
3. The coverage for the Domestic Partner will be the same as if covering a Spouse; however, such coverage will generally result in imputed income for the employee.
4. The Domestic Partner will generally not qualify as a tax dependent and as such, the employee will be taxed on the value of the benefit provided to him or her. This is called "imputed income" and the employee will have to pay tax on this amount. If an employee elects coverage for a domestic partner, the contributions the employee makes toward the cost of this domestic partner coverage must be deducted on an after-tax basis, in accordance with IRS regulations. In addition, the amount an employer pays toward the cost of domestic partner coverage must be imputed as income and therefore is taxable to the employee.
5. When an eligible employee submits the request to enroll a domestic partner in this Plan, the Administration Office will notify the employee's employer of the proposed enrollment. That employer must agree to include in the employee's W-2 statement, as taxable income to the employee, the fair market value of the coverage afforded to the domestic partner as a dependent of the employee. The employer must also agree to pay any and all payroll taxes related to the taxable income shown on the employee's W-2 statement. Should the employer believe that the extension of this benefit to a particular domestic partner does not constitute taxable income to the employee, due to an interpretation of the Internal Revenue Code Section 152 and all related sections, and on that basis not agree to report income and pay taxes as described in this section, the employer must agree to accept full and sole responsibility for that determination.
6. A Domestic Partner (who meets the definition of Domestic Partner as defined in this Plan) may enroll at any time. Coverage of the Domestic Partner will become effective on the first day of the month in which the Administration Office receives the following:
   - The notarized Declaration of Domestic Partnership
   - The Plan's completed Domestic Partner enrollment forms
   - An agreement as to tax reporting and payment by the employer of the employee who is seeking to add a Domestic Partner.

   The Trustees reserve the right to require additional proof of ongoing eligible dependent domestic partner status at any time.
7. In no event will the dependent children of an eligible Domestic Partner be deemed eligible as a dependent under this Plan.
8. A dependent Domestic Partner losing eligibility will be entitled to elect a "COBRA-like" continuation of coverage but not Life Insurance. See also the events causing termination of Domestic Partner coverage in the section of this chapter

called "When Coverage Ends." For help with questions about the tax implications of covering a domestic partner contact the Administration Office.

RETIREE ELIGIBILITY

1. An eligible Retiree:
   a) is an individual who receives a pension benefit from the UNITE HERE National Retirement Fund; or
   b) receives a Social Security permanent disability award; **or**
   c) was an employee for whom contributions to the South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund were made for each of five years immediately preceding the year in which the individual turned 65 years of age.
2. The Retiree must:
   a) apply to participate in the Plan; and
   b) maintain membership in Hotel Employees, Restaurant Employees Local #19; and
   c) make self-payments of premiums to the Trust Fund office on or before the date that are due; and
   d) maintain eligibility without a gap from the date the active employee became eligible as a retiree, unless he or she retired prior to September 1, 1980. If the individual retired prior to September 1, 1980 and meets provisions 2) a, b and c above, the individual will be an eligible retiree.
3. All eligible retirees will become eligible on the first day of the month that falls on or next follows three consecutive months of self-payment.
4. A retiree who loses eligibility under this Plan will never be able to re-establish eligibility under this Plan.
5. See also the Coordination of Benefits chapter for information on how this Plan coordinates its benefit payment with Medicare.

SPECIAL ENROLLMENT

1) Newly Acquired Spouse and/or Dependent Child(ren) (as these terms are defined under this Plan)

- **If <u>you, the employee, are enrolled</u> for individual coverage** under this Plan and if you acquire a Spouse by marriage, or if you acquire any Dependent Children by birth, adoption or placement for adoption, you may request enrollment for your newly acquired Spouse and/or any Dependent Child(ren) no later than 30 days after the date of marriage, birth, adoption or placement for adoption.
- **If <u>you are not enrolled</u> for individual coverage** under this Plan and if you acquire a Spouse by marriage, or if you acquire any Dependent Children by birth, adoption or placement for adoption, you may request enrollment for yourself and/or your newly acquired Spouse and/or any Dependent Child(ren) no later than 30 days after the date of marriage, birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a newly acquired Dependent.
- **If you did not enroll your Spouse for coverage within 30 days of the date on which he or she became eligible for coverage under this Plan,** and if you subsequently acquire a Dependent Child by birth, adoption or placement for adoption, you may request enrollment for your Spouse and/or your newly acquired Dependent Child and/or any Dependent Child(ren) no later than 30 days after the date of your newly acquired Dependent Child's birth, adoption or placement for adoption. If you, the employee, are not already enrolled for coverage, you must request enrollment for yourself in order to enroll a newly acquired Dependent.
- To request Special Enrollment, follow the procedure described under "Enrollment Procedure" in this chapter.

2) Loss Of Other Coverage: If, you did not request enrollment under this Plan for yourself, your Spouse and/or any Dependent Child(ren) within 30 days after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy including COBRA Continuation Coverage, certain types of individual insurance, Medicare, Medicaid, or other public program; **and** you, your Spouse and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; you may request enrollment for yourself and/or your Spouse and/or any Dependent Child(ren) within 30 days after the termination of 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
- of 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 was provided under COBRA Continuation Coverage, and the COBRA coverage was **"exhausted"** or
- of 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
- of the other plan ceases to offer coverage to a group of similarly situated individuals; or
- of the loss of dependent status under the other plan's terms; or
- of the termination of a benefit package option under the other plan, unless substitute coverage offered.

See also the Enrollment Procedures section of this chapter for more information. Proof of loss of coverage is required by this Plan. Loss of coverage does not apply to Retirees and their dependents.

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

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

3) Start of Coverage Following Special Enrollment:

- **Coverage of an individual enrolling due to loss of other coverage or because of marriage:** If the individual requests Special Enrollment within 30 days of the date of the event that created the Special Enrollment opportunity, (except for newborn and newly adopted child below) generally coverage will become effective on the date of the event that created the Special Enrollment opportunity (e.g. the marriage).
- **Coverage of a newborn or newly adopted newborn Dependent Child** who is properly enrolled within 30 days after birth will become effective as of the date of the child's birth.
- **Coverage of a newly adopted Dependent Child or Dependent Child Placed for Adoption** who is properly enrolled more than 30 days after birth, but within 30 days after the child is adopted or placed for adoption, will become effective as of the date of the child's adoption or placement for adoption, whichever occurs first.
- Individuals enrolled during Special Enrollment have the same opportunity to select Plan benefit options (when such options exist) at the same costs and the same enrollment requirements as are available to similarly situated employees at Initial Enrollment.

4) Failure to Enroll During Special Enrollment (Very Important Information):

- If you fail to request enrollment for yourself and/or any of your Eligible Dependents within 30 days after the date on which you and/or they first become eligible for Special Enrollment, you will not be able to enroll them until the next Open Enrollment period.

OPEN ENROLLMENT

1) Open Enrollment Period: Open Enrollment is the period of time during the fall of each year to be designated by the Plan Administrator or its designee during which eligible employees may make the elections specified below. Enrollment forms and information may be obtained from the Administration Office.

2) Elections Available During Open Enrollment: During the Open Enrollment period, you may elect, for yourself and your Eligible Dependents who are enrolled for coverage, to **enroll** in one of the health plans offered and/or the dental plans offered, or **add or drop** Eligible Dependents to the medical or dental coverage, or **change** medical plan options or dental plan options. **Note: Central Coast members do not have a dental plan option as the only dental plan available to them is the MetLife PPO Dental Plan described in this document**.

3) Restrictions on Elections During Open Enrollment: No Dependent may be covered unless you are covered. You and all your covered Eligible Dependents must be enrolled for the same medical, dental and vision coverages. All relevant parts of the enrollment form must be completed; and, the form must be submitted before the end of the Open Enrollment period to the Administration Office along with proof of Dependent status (as requested) and pay any required contribution for that dependent's coverage. See also the Enrollment Procedures section of this chapter for more information.

4) **Start of or Changes to Coverage Following Open Enrollment**:
   - If you or your Spouse or Dependent Child(ren) are **enrolled for the first time during an Open Enrollment period**, that person's coverage will begin on the first day of the new Calendar Year following the Open Enrollment.
   - If you or your Spouse or Dependent Children are **changing or discontinuing coverage during Open Enrollment**, such changes will become effective on the first day of the new Calendar Year following Open Enrollment.

5) **Failure to Make a New Election During Open Enrollment**: If you have been enrolled for coverage and you fail to make a new election during the Open Enrollment period, you will be considered to have made an election to retain the same medical and dental coverage you had during the preceding Plan Year.

6) **Failure to Enroll or Change Coverage During Open Enrollment (Very Important Information):** If you fail to enroll or change coverage for yourself and/or any of your Eligible Dependents within the Open Enrollment period (unless your Eligible Dependents qualify for Special Enrollment described in the previous section of this chapter), you will not be able to enroll or change coverage for yourself and/or them until the next annual Open Enrollment period.

7) **Late Enrollment:** This Plan does not offer a Late Enrollment provision. See the Special Enrollment or Open Enrollment provisions of this chapter.

NEWBORN DEPENDENT CHILDREN (SPECIAL RULE FOR COVERAGE)

1) Your newborn Dependent Child(ren) will be covered from the date of birth (coverage includes treatment of injury, sickness, birth defects and premature birth but not routine nursery charges), **only if** you request enrollment of that newborn Dependent Child for coverage within 30 days after the child's date of birth and submit a completed written enrollment form to the Administration Office and provide proof of Dependent status (if requested) and pay any required contribution for that Dependent Child's coverage.
2) Remember that you may not enroll a newborn Dependent Child for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and the Enrollment Procedure in this chapter.

ADOPTED DEPENDENT CHILDREN (SPECIAL RULE FOR COVERAGE)

1) Your adopted Dependent Child will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, provided you follow the enrollment procedure of this Plan. A child is "Placed for Adoption" with you on the date you first become legally obligated to provide full or partial support of the child whom you plan to adopt.
2) A Newborn Child who is Placed for Adoption with you within 30 days after the child was born will be covered from the date the child was placed for adoption if you comply with the Plan's requirements for obtaining coverage for a Newborn Dependent Child, described above in this chapter.
3) A Dependent Child adopted more than 30 days after the child's date of birth will be covered from the date that child is adopted or "Placed for Adoption" with you, whichever is earlier, if you submit a completed written enrollment form to the Administration Office and provide of proof of Dependent status (if requested) and pay any required contribution for that Dependent Child's coverage, within 30 days of the child's adoption or placement for adoption.
4) If the adopted Dependent child is not properly enrolled in a timely manner, you must wait until the next Open Enrollment period or Special Enrollment period, if applicable. However, if a child is Placed for Adoption with you, and if the adoption does not become final, coverage of that child will terminate as of the date you no longer have a legal obligation to support that child. Remember that you may not enroll an adopted Child or a Child Placed for Adoption for coverage unless you, the employee, are also enrolled for coverage. See also the Special Enrollment provisions and Enrollment Procedure in this chapter.

WHEN YOU AND ANY OF YOUR DEPENDENTS BOTH WORK FOR AN EMPLOYER WHO PARTICIPATES IN THE TRUST FUND: (Special Rule for Enrollment)

1. No individual may be covered under this Plan both as an employee and as a Dependent or Domestic Partner, nor may any Dependent Child be covered as the Dependent of more than one employee.
2. **If, while your family coverage is in effect, any of your Dependent Children becomes an employee of an employer who participates in the Trust Fund and becomes eligible for coverage as an employee**:
   - That child will cease to be a Dependent Child, and may enroll for coverage as an employee, in which case coverage as a Dependent Child will terminate as of the date coverage as an employee begins.
   - If the employee-child terminates employment or has a reduction in hours that would ordinarily result in a termination of coverage, and still qualifies as a Dependent Child, the employee-child will immediately be deemed to be covered as a Dependent Child of the employee-parent. As a result, the employee-child will not sustain a loss of coverage because of termination of employment or reduction in hours. Contributions for Dependent coverage will be deducted from the pay of the employee-parent and will be adjusted as may be required when a Dependent Child becomes an employee and

ceases to have coverage as a Dependent Child, or when the employee-child ceased to be an employee and resumes coverage as a Dependent Child.

WHEN COVERAGE ENDS

Employee coverage ends on the earliest of the following:

- the end of the period for which the last required contribution was made; or
- you are no longer eligible to participate in the Plan; or
- the end of the period for which the employee or their employer has paid on your behalf; or
- the date the Plan is terminated/discontinued; or
- the date of your death.

Retiree coverage ends on the earliest of:

- the end of the month in which the retiree fails to make any required contributions for coverage; or
- the date of the Retiree's death; or
- the date the Plan is discontinued; or
- the end of the month in which the retiree no longer meets the definition of a Retiree or is no longer eligible to participate in the Plan.

Dependent or Domestic Partner coverage ends on the earliest of the following:

- the date the Employee's coverage ends; or
- the date the Dependent or Domestic Partner enters the Armed Forces of any country on full-time active duty; or
- the date your covered Spouse or Dependent Child(ren) or Domestic Partner no longer meet the definition of Spouse or Dependent Child(ren), or Domestic Partner as provided in the Definitions chapter of this document; or
- for Dependents under a QMCSO, the date that equates to the expiration of the period of coverage stated in the QMCSO; or
- the end of the period for which the last required contribution was made for coverage of your Spouse or Dependent Child(ren) or Domestic Partner; or
- the date of the Dependent's or Domestic Partner's death.

EXTENSION OF COVERAGE

If your coverage ends for any reason while you are disabled, coverage for the disabling condition will be extended without payment. The extension in coverage will end on the earliest of:

- 12 months from the date your coverage ends under this Plan; or
- The date you are no longer disabled; or
- The date you become insured under another group policy that does not limit or exclude coverage of the disabling condition, or under Medicare or Medicaid.

NOTICE TO THE PLAN

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

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

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

WHEN THE PLAN CAN END YOUR COVERAGE FOR CAUSE

The Board of Trustees may end your coverage and/or the coverage of any of your covered Dependents for cause 60 days after it gives you written notice of its finding that:

1. you or your covered Dependent **made a fraudulent statement**, a material misrepresentation, or omitted any material information in any enrollment, claim or other form in order to obtain coverage, services or benefits under the Plan; or

2. you or your covered Dependent **allowed anyone else to use the identification card** that entitles you or your covered Dependent to coverage, services or benefits under the Plan; or
3. you or your covered Dependent **altered any prescription** furnished by a Physician.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

The Family and Medical Leave Act (FMLA) enacted by Congress in 1993 provides that in certain situations certain employers are required to grant unpaid leave to employees for up to 12 weeks per year for specified family or medical purposes, such as the birth or adoption of a child, to provide care of a husband, wife (but not a domestic partner), child or parent who is seriously ill, or for your own serious illness. The federal legislation specifically provides that, when applicable, more liberal state laws or collective bargaining agreements regarding FMLA are permitted.

It is not the role of the Trustees or Trust Fund to determine whether or not an individual employee is or is not entitled to leave. Entitlement to leave under FMLA and the continuation of benefits should be resolved between the employee and their employer. To the extent that members **are** entitled to leave with continuation of their health care coverage, the Trust Fund will provide continuing health care coverage **as long as the required monthly contributions are received from the contributing employer and as applicable, the employee (such as for dependent coverage)**.

LEAVE FOR MILITARY SERVICE/UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA)

If you go into active military service for **up to 31 days**, you can continue your health care coverage under this Plan during that leave period if you continue to pay your contributions for that coverage during the period of that leave. If you go into active military service for **more than 31 days**, you should receive military health care coverage at no cost; however, you may also continue this group health plan coverage under the provisions of USERRA, at your own expense, as follows:

- If you elect USERRA continuation coverage **before** December 10, 2004 the maximum period for this coverage is up to 18 months.
- If you elect USERRA continuation coverage on or after December 10, 2004 the maximum period for this coverage is up to 24 months.

When your coverage under this Plan terminates because of your reduction in hours due to your military service, you and your eligible dependents may also have COBRA rights. See also the COBRA chapter of this document. Questions regarding your entitlement to this leave and to the continuation of health care coverage should be referred to the Administration Office.

REINSTATEMENT OF COVERAGE AFTER LEAVES OF ABSENCE

If your coverage ends while you are on an approved leave of absence for family, medical or military leave, your coverage will be reinstated consistent with your hour bank accumulation, lag month and other provisions described in the initial eligibility provisions of this Plan. Questions regarding your entitlement to an approved leave of absence and to the continuation of health care coverage should be referred to the Administration Office.

CONTINUATION OF COVERAGE

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

CERTIFICATION OF COVERAGE WHEN COVERAGE ENDS

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

Procedure for Requesting and Receiving a Certificate of Creditable Coverage: A certificate will be provided upon request for such a certificate that is received by the Administration Office within two years after the date coverage ended under this Plan. The request should include the names of the individuals for whom a certificate is requested (including spouse and dependent children) and the address where the certificate should be mailed. The address, telephone and fax numbers of the Administration Office is on the Quick Reference Chart in the front of this document. A copy of the certificate will be mailed by the Plan to the address indicated. See the COBRA chapter for an explanation of when and how certificates of coverage will be provided after COBRA coverage ends.

CONSOLIDATED OMNIBUS BUDGET RECONCILIATION ACT (COBRA): TEMPORARY CONTINUATION OF HEALTH CARE COVERAGE

CONTINUATION OF COVERAGE (COBRA)

Entitlement to COBRA Continuation Coverage: In compliance with a federal law commonly called COBRA, this Plan, offers its eligible employees and their covered Dependents (called "Qualified Beneficiaries") the opportunity to elect a temporary continuation of the group health coverage ("COBRA Continuation Coverage") sponsored by the Trust Fund, including medical, coverage only, or medical and dental coverage only or medical, dental and vision coverage (the "Plan"), when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law). Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

NOTE: Domestic Partners are offered the ability to elect COBRA-like continuation of coverage when coverage ends (described in this chapter); however, Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary.

COBRA Administrator:

The name, address and telephone number of the COBRA Administrator responsible for the administration of COBRA, and to whom you can direct questions about COBRA, is shown in the Quick Reference Chart in the front of this document.

IMPORTANT:

This chapter serves as a notice to summarize your rights and obligations under the COBRA continuation coverage law. It is provided to all members and their dependents and is intended to inform them in a summary fashion of their rights and obligations under the continuation provisions of the federal law. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your spouse take the time to read this notice carefully and be familiar with its contents.

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

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event, that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. A parent or legal guardian may elect COBRA for a minor child. A Qualified Beneficiary also has the same rights and enrollment opportunities under the Plan as other participants including Special Enrollment.

1. "**Qualified Beneficiary**": Under the law, a Qualified Beneficiary is any Member or the Spouse or Dependent Child of a Member who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the Member during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. A person who becomes the new spouse of an existing COBRA participant during a period of COBRA Continuation Coverage is not a Qualified Beneficiary.
2. **"Qualifying Event"**: Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the Participant LOSES health care coverage under this Plan**. If a Participant has a qualifying event but does not lose their health care coverage under this Plan, (*e. g.* Member continues working even though entitled to Medicare) then COBRA is not yet offered.

Special Enrollment Rights

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

Maximum Period of COBRA Continuation Coverage

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

Medicare Entitlement

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

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

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries		
	Employee	Spouse	Dependent Child(ren)
Employee terminated (for other than gross misconduct).	18 months	18 months	18 months
Employee reduction in hours worked (making employee ineligible for the same coverage).	18 months	18 months	18 months
Employee dies.	N/A	36 months	36 months
Employee becomes divorced or legally separated.	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

Procedure on When the Plan Must Be Notified of a Qualifying Event (Very Important Information)

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

That notice should be sent to the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document. The written notice can be sent via first class mail or be hand-delivered and is to include your name, the qualifying event, the date of the event, and appropriate documentation in support of the qualifying event, such as divorce documents.

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

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

Notices Related to COBRA Continuation Coverage

When:

a. **your employer notifies the Plan** that your health care coverage has ended because your employment terminated, your hours are reduced so that you are no longer entitled to coverage under the Plan, you died, have become entitled to Medicare, or

b. **you notify the COBRA Administrator** that a Dependent Child lost Dependent status, you divorced or have become legally separated,

then the COBRA Administrator will give you and/or your covered Dependents notice of the date on which your coverage ends and the information and forms needed to elect COBRA Continuation Coverage. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to COBRA coverage. Under the law, you and/or your covered Dependents will then have only 60 days from the date of receipt of that notice, to elect COBRA Continuation Coverage.

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

The COBRA Continuation Coverage That Will Be Provided

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage that you had when the event occurred that caused your health coverage under the Plan to end, but you must pay for it. See the section on Paying for COBRA Continuation Coverage that appears later in this chapter for information about how much COBRA Continuation Coverage will cost you and about grace periods for payment of those amounts. If there is a change in the health coverage provided by the Plan to similarly situated active employees and their families, that same change will apply to your COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

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

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

The Trade Act

The **Trade Adjustment Assistance Reform Act of 2002** (also called the Trade Act) creates a new tax credit for certain individuals who become eligible for trade adjustment assistance and for certain retired employees who are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC) (called eligible individuals). Under the new tax provisions, eligible individuals can either take a tax credit or get advance payment of 65% of premiums paid for qualified health insurance, including COBRA. If you have questions about these new tax provisions call the Health Care Tax Credit Customer Contact Center toll free at 1-866-628-4282 (TTD/TTY: 1-866-626-4282). See also the information about the Trade Act at: www.doleta.gov/tradeact/2002act_index.cfm

Grace Periods

The initial payment for the COBRA Continuation Coverage is due to the COBRA Administrator 45 days after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect. After the initial COBRA payment, subsequent payments are due on the first day of each month, but there will be a 30-day grace period to make those payments. If payments are not made within the time indicated in this paragraph, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

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

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

Addition of Newly Acquired Dependents

If, while you (the employee) are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that spouse or child for coverage for the balance of the period of COBRA Continuation Coverage if you do so within 31 days after the marriage, birth, adoption, or placement for adoption. Adding a Spouse or Dependent Child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a dependent.

Loss of Other Group Health Plan Coverage

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

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

Notice of Unavailability of COBRA Coverage

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

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

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced or legally separated, become entitled to Medicare, or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected spouse and/or child is extended to 36 months measured from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier, as described below). Medicare entitlement is not a qualifying event under this Plan and as a result, Medicare entitlement following a termination of coverage or reduction in hours will not extend COBRA to 36 months for spouses and dependents who are qualified beneficiaries.

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

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

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

In no case is anyone else entitled to COBRA Continuation Coverage for more than a total of 36 months.

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

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

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

Early Termination of COBRA Continuation Coverage

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

1. The date on which the Member's employer no longer provides group health coverage to any of its employees;
2. The first day of the time period for which the amount due for the COBRA Continuation Coverage is not paid on time;
3. The date, after the date of the COBRA election, on which the Participant first becomes entitled to Medicare;
4. The date, after the date of the COBRA election, on which the Participant first becomes covered under another group health plan and that plan does not contain any legally applicable exclusion or limitation with respect to a Pre-Existing Condition that the Participant may have;
5. The date the Plan has determined that the Participant must be terminated from the Plan for cause;
6. During an extension of the maximum coverage period to 29 months due to the disability of the Member, the disabled person is determined by the Social Security Administration to no longer be disabled.

Notice of Early Termination of COBRA Continuation Coverage

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

No Entitlement to Convert to an Individual Health Plan after COBRA Ends

There is no opportunity to convert to an individual health plan after COBRA ends under this self-funded Plan. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

COBRA Questions or To Give Notice of Changes in Your Circumstances

- If you have any questions about your COBRA rights, please contact the COBRA Administrator whose address is listed on the Quick Reference Chart in the front of this document.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Continuation Coverage, you <u>must</u> notify the COBRA Administrator:

1. within 30 days of a **change in marital status (e.g. marry, divorce)**; or have **a new dependent child**; or
2. within 60 days of the date you or a covered dependent spouse or child has been determined to be **totally and permanently disabled** by the Social Security Administration; or
3. within 60 days if a covered child **ceases to be a "dependent child"** as that term is defined by the Plan; or
4. promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

Certification of Coverage When Coverage Ends

A certificate will be provided to you and/or any covered Dependent upon receipt of a request for such a certificate if that request is received by the Plan Administrator within two years after the later of the date your coverage under this Plan ended or the date COBRA coverage ended. See the Eligibility chapter for the procedure for requesting a certificate of coverage.

If your coverage under this Plan ends, and you and/or your covered Dependents become eligible for coverage under another group health plan, or if you buy, for yourself and/or your covered Dependents, a health insurance policy, you may need this certificate in order to reduce any exclusion for Pre-Existing Conditions that may apply to you and/or your covered Dependents in that new group health plan or health insurance policy. The certificate will indicate the period of time you and/or they were covered under this Plan, and certain additional information that is required by law.

Marketplace Coverage (Covered California)

There may be other coverage options for you and your family. You may wish to purchase coverage from the Health Insurance Marketplace ("Covered California"). In the Marketplace, you could be eligible for tax credits that lower your monthly premiums right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll.

Being eligible for COBRA or a self-pay option does not limit your eligibility for coverage for a tax credit through the Marketplace. However, you should be aware that if you elect COBRA or a self-pay option upon losing your regular coverage, you will be ineligible for Marketplace coverage until the earlier of (1) the date you exhaust your COBRA or self-pay eligibility or (2) the next annual Marketplace open enrollment (October-December) unless you are entitled to special enrollment (e.g., you are adding a dependent).

You can find out more about your Marketplace options at the Covered California website: www.coveredca.com.

SELF FUNDED MEDICAL PLAN

OVERVIEW OF THE MEDICAL PLAN

The Aetna PPO Plan gives you the freedom to use any hospital or physician in California and throughout the United States for covered medically necessary services. Out-of-pocket expenses are much lower and benefits are paid at a higher level if you visit an Aetna Network provider in place of a non-network provider. In addition, your MaxorPlus Prescription Drug Plan provides access to a wide choice of participating pharmacies in California and throughout the United States.

Aetna offers many services free of charge, such as a 24-hour nurse line for your health questions, and several member wellness programs. Aetna also offers many discount programs, including savings on gym memberships, eyeglasses, contacts, weight loss programs, chiropractic visits, and much more. Additionally, Aetna offers a one-stop online resource, Aetna Navigator®, for managing your health and benefits. Aetna Navigator® can be used to order ID cards, see who is covered on your plan, review coverage, and much more.

ELIGIBLE MEDICAL EXPENSES

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expenses," and they are limited to those that are:

1. determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that the charges are **"Usual and Customary"** (as those terms are defined in the Definitions chapter of this document); and
2. **not services or supplies that are excluded** from coverage (as provided in the Exclusions chapter of this document); and
3. **not services or supplies in excess** of any applicable Annual Maximum Plan Benefits shown in the Schedule of Medical Benefits and
4. **for the diagnosis or treatment of a covered injury or illness**.

Generally, **the Plan will not reimburse you for all Eligible Medical Expenses**. Usually, you will have to satisfy some Deductibles and pay some Coinsurance or make some Copayments toward the amounts you incur that are Eligible Medical Expenses.

NON-ELIGIBLE MEDICAL EXPENSES

The Plan will not reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost of all expenses that are not determined to be medically necessary, determined to be in excess of the Usual and Customary charges, not covered by the Plan, in excess of any applicable Maximum Plan Benefit.

PPO NETWORK HEALTH CARE PROVIDER SERVICES

As part of its cost containment effort, your Plan provides a voluntary Preferred Provider Organization (PPO) option. There are special rates which have been negotiated with certain hospitals, doctors and other health care providers (called Preferred Providers, In-Network Providers or PPO Providers). These special discounted rates save you money because the lower fees mean you and your covered dependents pay less money out of your pocket.

It is your responsibility to confirm that your doctor/healthcare provider is a participant of the PPO Network. Additions and changes to the PPO membership list are made continuously. Please contact the PPO Network before you plan a provider visit or admission to confirm that your provider is still a member of the PPO. Note also that some physicians who have been in practice for many years may have reached the maximum patient load which they can effectively handle and cannot accept new patients for a while. If you are told that a physician's practice is full, please make another selection from the list of PPO providers.

While you may use any health care provider you choose, there are **distinct advantages to using PPO participating providers** as discussed below:

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

  Remember, because providers are added to and dropped from the PPO network periodically throughout the year it is best if you ask your health care provider IF they are still participating with the PPO each time BEFORE you seek services. To verify which hospitals, physicians, surgery centers and other providers are currently in the PPO Network, call the PPO Network (whose name and phone number are listed on the Quick Reference Chart in the front of this document).

PPO Network Provider Directory: There is no cost to you for the PPO Provider Directory. PPO providers are posted on the PPO Network's website that is listed on the Quick Reference Chart in the front of this document.

- **OUT-OF-NETWORK SERVICES:** Out-of-Network (also called Non-Network or Non-PPO) health care providers have no agreements with the Plan, typically do not offer a discount and are generally free to set their own charges for the services or supplies they provide. The Plan will reimburse benefits based on the Usual and Customary Charge (as defined in this document) for any medically necessary services or supplies, subject to the Plan's deductibles, coinsurance (on non-discounted services), copayments limitations and exclusions. Plan participants must submit proof of claim before any such reimbursement will be made. **Out-of-Network Health Care Providers may bill a Plan participant for any balance that may be due in addition to the amount payable by the Plan, also called balance billing.**
- **OUT OF AREA SERVICES:** The Plan Administrator or its designee may determine that in certain circumstances the Plan will pay the in-network level of coinsurance toward covered charges when you used the services of an out of network provider because of one of the following reasons:
  a. Confinement is due to an emergency;
  b. When the patient resides more than 50 miles from the nearest appropriate in-network PPO provider;
  c. The patient required treatment by a non-PPO provider because no qualified PPO provider was available;
  d. You cannot be moved because your condition is life-threatening, as determined by the Physician in attendance;
  e. You are unable to communicate your choice of hospitals;
  f. Local law or regulation dictates that you be transported to a specific hospital; or
  g. The PPO Physician or hospital in which you are being treated dictates that you be confined/transferred to a non-PPO facility due to medical necessity.

DEDUCTIBLE

- The deductible is applied to the Eligible Medical Expenses in the order in which claims are received by the Plan.
- When the deductible applies, the member (and **not** the Plan) is responsible for paying the Eligible Medical Expenses until the annual Deductible is satisfied and then the Plan pays benefits under the appropriate in- or out-of-network coinsurance level.
- Only Eligible Medical Expenses can be used to satisfy the Plan's Deductible. As a result, Non-Eligible Medical Expenses (described above) and outpatient prescription drug expenses do not apply toward the Deductible.

COINSURANCE

Once you've met your annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (and **not** the Plan) are responsible for paying the rest. The part you pay is called the Coinsurance. Remember, if you use the services of a Health Care Provider who is a member of the Plan's PPO, you will be responsible for paying less money out of your pocket than if you use a non-PPO provider.

Coinsurance When You Don't Comply with Utilization Management Programs: If you fail to follow certain requirements of the Plan's Utilization Management Program (as described in the Utilization Management chapter of this document) the Plan will apply a $400 per occurrence penalty separately to each type of out-of-network expense. Any additional amount you have to pay will not accumulate to meet the Plan's Deductible or out-of-pocket limit. This feature is described in more detail in the Utilization Management chapter of this document.

SCHEDULE OF MEDICAL BENEFITS

A schedule of the Self-Funded Medical Plan's benefits appears on the following pages in a chart format. Each of the Plan's Medical Benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second (In-Network) and third (Out-of-Network) columns.

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

Comprehensive Major Medical Aetna PPO Plan A
Schedule of Benefits

PPO PLAN BENEFIT SUMMARY PLAN FEATURES	In-Network Provider YOU PAY	Non-Network Provider YOU PAY
Deductible (per calendar year)	$ 250 Individual $ 500 Family	$ 500 Individual $ 1,000 Family

- All covered expenses, except prescription drugs, accumulate separately toward the In-Network or Non-Network Deductible.
- Unless otherwise indicated, the Deductible must be met prior to benefits being payable.
- Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.

Member Coinsurance Applies to all expenses unless otherwise stated.	20%	40%
Calendar Year Out-of-Pocket Maximum	$ 2,500 Individual $ 5,000 Family	$ 5,000 Individual $ 10,000 Family

- All covered expenses, except prescription drugs, accumulate separately toward both the In-Network and Non-Network Calendar Year Out-of-Pocket Maximum.
- Certain member cost sharing elements may not apply toward the Calendar Year Out-of-Pocket Maximum.
- Only those out-of-pocket expenses resulting from the application of calendar year deductible and coinsurance percentage (except any penalty amounts) may be used to satisfy the Calendar Year Out-of-Pocket Maximum.
- Once Family Calendar Year Out-of-Pocket Maximum is met, all family members will be considered as having met their Calendar Year Out-of-Pocket Maximum for the remainder of the calendar year.

Lifetime Maximum
Unlimited except where otherwise indicated.

Primary Care Physician (PCP) Selection	Optional	Not Applicable

Pre-Certification Requirements -
Pre-Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required – the penalty applied separately to each type of expense is $400 per occurrence. Only care that is determined to be medically necessary is considered a covered expense.

Referral Requirement	None	None

PREVENTIVE CARE	In-Network Provider	Non-Network Provider
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months age 18 and older.	Covered 100%; deductible waived	40% after deductible
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 18.	Covered 100%; deductible waived	40% after deductible
Routine Gynecological Care Exams One exam per calendar year. Includes routine tests and related lab fees. May choose OB/GYNs as PCP's	Covered 100%; deductible waived	40% after deductible

PREVENTIVE CARE (continued)	In-Network Provider	Non-Network Provider
	YOU PAY	YOU PAY
Routine Mammograms One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.	Covered 100%; deductible waived	40% after deductible
Routine Digital Rectal Exam For covered males age 40 and over.	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	40% after deductible
Routine Hearing Exams 1 routine exam per 12 months.	$10 office visit copay; deductible waived	40% after deductible
PHYSICIAN SERVICES	**In-Network Provider**	**Non-Network Provider**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$10 copay; deductible waived	40% after deductible
Specialist Office Visits	$10 copay; deductible waived	40% after deductible
Allergy Testing	20%; deductible waived	40% after deductible
Allergy Injections	20% after deductible	40% after deductible
DIAGNOSTIC PROCEDURES	**In-Network Provider**	**Non-Network Provider**
Diagnostic X-ray If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	No charge	40% after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	No charge	40% after deductible
Diagnostic Outpatient Complex Imaging	No charge	40% after deductible
EMERGENCY MEDICAL CARE	**In-Network Provider**	**Non-Network Provider**
Urgent Care Provider	$50 copay/visit; deductible waived	40%; deductible waived
Emergency Room	20% after $100 copay (waived if admitted); after deductible	Same as In-Network care.

EMERGENCY MEDICAL CARE (continued)	In-Network Provider	Non-Network Provider
	YOU PAY	**YOU PAY**
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20% after deductible	20% after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**In-Network Provider**	**Non-Network Provider**
Inpatient Coverage Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% after deductible	40% after deductible
Inpatient Maternity Coverage Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% after deductible	40% after deductible
Outpatient Hospital Expenses (including surgery) Cost sharing applies to all covered benefits incurred during an outpatient visit.	20% after deductible	40% after deductible
MENTAL HEALTH SERVICES	**In-Network Provider**	**Non-Network Provider**
Inpatient Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% per admission after deductible	40% per admission after deductible
Outpatient Cost sharing applies to all covered benefits incurred during an outpatient visit.	$10 copay/visit; deductible waived	40% per visit after deductible
ALCOHOL/DRUG ABUSE SERVICES	**In-Network Provider**	**Non-Network Provider**
Inpatient Cost sharing is based on the type of service performed and the place of service where it is rendered.	20% per admission after deductible	40% per admission after deductible
Outpatient Cost sharing applies to all covered benefits incurred during an outpatient visit.	$10 copay/visit; deductible waived	40% per visit after deductible
OTHER SERVICES	**In-Network Provider**	**Non-Network Provider**
Convalescent Facility Limited to 60 days per calendar year. Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% after deductible	40% after deductible
Home Health Care Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20% after deductible	40% after deductible
Hospice Care - Inpatient Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% after deductible	40% after deductible
Hospice Care - Outpatient Cost sharing applies to all covered benefits incurred during an outpatient visit.	20% after deductible	40% after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy. Limited to 30 visits per calendar year	$10 copay; deductible waived	40% after deductible

OTHER SERVICES (continued)	In-Network Provider YOU PAY	Non-Network Provider YOU PAY
Spinal Manipulation Therapy Limited to $2,000 per calendar year.	$10 copay; deductible waived	40% after deductible
Durable Medical Equipment Maximum benefit of $10,000 per member per calendar year.	20% after deductible	40% after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered same as any other medical expense.	Covered same as any other medical expense.
Transplants	20% after deductible In-Network coverage is provided at an Institution of Excellence (IOE) approved by the Plan	40% after deductible Non-Network coverage is provided at a Non-IOE facility.
Non-Network Services	Coverage provided at the Non-Network benefit level of the plan.	

FAMILY PLANNING	In-Network Provider	Non -Network Provider
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Diagnosis and treatment of the underlying medical condition.		
GIFT (gamete intrafallopian transfer)	Not Covered	Not Covered
Comprehensive Infertility Services Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime).	20% after deductible	40% after deductible
Advanced Reproductive Technology (ART) ART services include: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.	Not Covered	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible may apply	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible

PHARMACY - MaxorPlus	In-Network Pharmacy YOU PAY	Non-Network Pharmacy YOU PAY
Retail Prescriptions **Up to a 30-day supply**		Not Covered
Generic Drugs	$10.00 Rx copay	NA
Formulary Brand-Name Drugs	$25.00 Rx copay	NA
Non-Formulary Brand-Name Drugs	$50.00 Rx copay	NA
Mail Order Prescriptions (Up to a 90-day supply)		Not Covered
Generic Drugs	$20.00 Rx copay	NA
Formulary Brand-Name Drugs	$50.00 Rx copay	NA
Non-Formulary Brand-Name Drugs	$100.00 Rx copay	NA

Comprehensive Major Medical Aetna PPO Plan B
Schedule of Benefits

PPO PLAN BENEFIT SUMMARY PLAN FEATURES	In-Network Provider YOU PAY	Non-Network Provider YOU PAY
Deductible (per calendar year)	$ 1,500 Individual $ 3,000 Family	$ 2,500 Individual $ 5,000 Family
• All covered expenses, except prescription drugs, accumulate separately toward the In-Network or Non-Network Deductible. • Unless otherwise indicated, the Deductible must be met prior to benefits being payable. • Once the Family Deductible is met, all family members will be considered as having met their Deductible for the remainder of the calendar year.		
Member Coinsurance Applies to all expenses unless otherwise stated.	20%	40%
Calendar Year Out-of-Pocket Maximum	$ 5,000 Individual $ 10,000 Family	$ 10,000 Individual $ 20,000 Family
• All covered expenses, except prescription drugs, accumulate separately toward both the In-Network and Non-Network Calendar Year Out-of-Pocket Maximum. • Certain member cost sharing elements may not apply toward the Calendar Year Out-of-Pocket Maximum. • Only those out-of-pocket expenses resulting from the application of calendar year deductible and coinsurance percentage (except any penalty amounts) may be used to satisfy the Calendar Year Out-of-Pocket Maximum. • Once Family Calendar Year Out-of-Pocket Maximum is met, all family members will be considered as having met their Calendar Year Out-of-Pocket Maximum for the remainder of the calendar year.		
Lifetime Maximum Unlimited except where otherwise indicated.		
Primary Care Physician (PCP) Selection	Optional	Not Applicable
Pre-Certification Requirements - Pre-Certification for Hospital Admissions, Treatment Facility Admissions, Convalescent Facility Admissions, Home Health Care, Hospice Care and Private Duty Nursing is required – the penalty applied separately to each type of expense is $400 per occurrence. Only care that is determined to be medically necessary is considered a covered expense.		
Referral Requirement	None	None
PREVENTIVE CARE	**In-Network Provider**	**Non-Network Provider**
Routine Adult Physical Exams/ Immunizations 1 exam every 12 months age 18 and older.	Covered 100%; deductible waived	40% after deductible
Routine Well Child Exams/Immunizations 7 exams in the first 12 months of life, 3 exams in the second 12 months of life, 3 exams in the third 12 months of life, 1 exam per year thereafter to age 18.	Covered 100%; deductible waived	40% after deductible
Routine Gynecological Care Exams One exam per calendar year. Includes routine tests and related lab fees. May choose OB/GYNs as PCP's	Covered 100%; deductible waived	40% after deductible

PREVENTIVE CARE (continued)	In-Network Provider	Non-Network Provider
	YOU PAY	**YOU PAY**
Routine Mammograms One baseline mammogram for covered females age 35-39, one mammogram per calendar year for covered females age 40 and over.	Covered 100%; deductible waived	40% after deductible
Routine Digital Rectal Exam For covered males age 40 and over.	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Prostate-specific Antigen Test For covered males age 40 and over.	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Colorectal Cancer Screening For all members age 50 and over.	Covered 100%; deductible waived	Member cost sharing is based on the type of service performed and the place of service where it is rendered
Routine Eye Exams 1 routine exam per 24 months.	Covered 100%; deductible waived	40% after deductible
Routine Hearing Exams 1 routine exam per 12 months.	$20 office visit copay; deductible waived	40% after deductible
PHYSICIAN SERVICES	**In-Network Provider**	**Non-Network Provider**
Office Visits to PCP Includes services of an internist, general physician, family practitioner or pediatrician.	$20 copay; deductible waived	40% after deductible
Specialist Office Visits	$20 copay; deductible waived	40% after deductible
Allergy Testing	20%; deductible waived	40% after deductible
Allergy Injections	20% after deductible	40% after deductible
DIAGNOSTIC PROCEDURES	**In-Network Provider**	**Non-Network Provider**
Diagnostic X-ray If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%	40% after deductible
Diagnostic Laboratory If performed as a part of a physician office visit and billed by the physician, expenses are covered subject to the applicable physician's office visit member cost sharing.	20%	40% after deductible
Diagnostic Outpatient Complex Imaging	20%	40% after deductible
EMERGENCY MEDICAL CARE	**In-Network Provider**	**Non-Network Provider**
Urgent Care Provider	$50 copay/visit; deductible waived	40%; deductible waived
Emergency Room	20% after $100 copay (waived if admitted); after deductible	Same as In-Network care.

EMERGENCY MEDICAL CARE (continued)	In-Network Provider	Non-Network Provider
	YOU PAY	**YOU PAY**
Non-Emergency Care in an Emergency Room	Not Covered	Not Covered
Emergency Use of Ambulance	20% after deductible	20% after deductible
Non-Emergency Use of Ambulance	Not Covered	Not Covered
HOSPITAL CARE	**In-Network Provider**	**Non-Network Provider**
Inpatient Coverage Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% after deductible	40% after deductible
Inpatient Maternity Coverage Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% after deductible	40% after deductible
Outpatient Hospital Expenses (including surgery) Cost sharing applies to all covered benefits incurred during an outpatient visit.	20% after deductible	40% after deductible
MENTAL HEALTH SERVICES	**In-Network Provider**	**Non-Network Provider**
Inpatient Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% per admission after deductible	40% per admission after deductible
Outpatient Cost sharing applies to all covered benefits incurred during an outpatient visit.	$20 copay/visit; deductible waived	40% per visit after deductible
ALCOHOL/DRUG ABUSE SERVICES	**In-Network Provider**	**Non-Network Provider**
Inpatient Cost sharing is based on the type of service performed and the place of service where it is rendered.	20% per admission after deductible	40% per admission after deductible
Outpatient Cost sharing applies to all covered benefits incurred during an outpatient visit.	$20 copay/visit; deductible waived	40% per visit after deductible
OTHER SERVICES	**In-Network Provider**	**Non-Network Provider**
Convalescent Facility Limited to 60 days per calendar year. Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% after deductible	40% after deductible
Home Health Care Each visit by a nurse or therapist is one visit. Each visit up to 4 hours by a home health care aide is one visit.	20% after deductible	40% after deductible
Hospice Care - Inpatient Cost sharing applies to all covered benefits incurred during an inpatient stay.	20% after deductible	40% after deductible
Hospice Care - Outpatient Cost sharing applies to all covered benefits incurred during an outpatient visit.	20% after deductible	40% after deductible
Private Duty Nursing - Outpatient	Not Covered	Not Covered
Outpatient Short-Term Rehabilitation Includes Speech, Physical, and Occupational Therapy. Limited to 30 visits per calendar year	$20 copay; deductible waived	40% after deductible
Spinal Manipulation Therapy Limited to $2,000 per calendar year.	$20 copay; deductible waived	40% after deductible

OTHER SERVICES (continued)	In-Network Provider YOU PAY	Non-Network Provider YOU PAY
Durable Medical Equipment Maximum benefit of $10,000 per member per calendar year.	20% after deductible	40% after deductible
Diabetic Supplies -- (if not covered under Pharmacy benefit)	Covered same as any other medical expense.	Covered same as any other medical expense.
Contraceptive drugs and devices not obtainable at a pharmacy (includes coverage for contraceptive visits)	Covered same as any other medical expense.	Covered same as any other medical expense.
Transplants	20% after deductible In-Network coverage is provided at an Institution of Excellence (IOE) approved by the Plan	40% after deductible Non-Network coverage is provided at a Non-IOE facility.
Non-Network Services	Coverage provided at the Non-Network benefit level of the plan.	

FAMILY PLANNING	In-Network Provider	Non -Network Provider
Infertility Treatment	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible
Diagnosis and treatment of the underlying medical condition.		
GIFT (gamete intrafallopian transfer)	Not Covered	Not Covered
Comprehensive Infertility Services Coverage includes Artificial Insemination (limited to six courses of treatment per member's lifetime) and Ovulation Induction (limited to six courses of treatment per member's lifetime).	20% after deductible	40% after deductible
Advanced Reproductive Technology (ART) ART services include: In vitro fertilization (IVF), zygote intra-fallopian transfer (ZIFT), gamete intrafallopian transfer (GIFT), cryopreserved embryo transfers, intracytoplasmic sperm injection (ICSI) or ovum microsurgery.	Not Covered	Not Covered
Voluntary Sterilization Including tubal ligation and vasectomy.	Member cost sharing is based on the type of service performed and the place of service where it is rendered; deductible may apply	Member cost sharing is based on the type of service performed and the place of service where it is rendered; after deductible

PHARMACY - MaxorPlus	In-Network Pharmacy YOU PAY	Non-Network Pharmacy YOU PAY
Retail Prescriptions **Up to a 30-day supply**		Not Covered
Generic Drugs	$10.00 Rx copay	NA
Formulary Brand-Name Drugs	$25.00 Rx copay	NA
Non-Formulary Brand-Name Drugs	$50.00 Rx copay	NA
Mail Order Prescriptions (Up to a 90-day supply)		Not Covered
Generic Drugs	$20.00 Rx copay	NA
Formulary Brand-Name Drugs	$50.00 Rx copay	NA
Non-Formulary Brand-Name Drugs	$100.00 Rx copay	NA

UTILIZATION MANAGEMENT (UM)

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

There are often less costly alternatives to expensive medical procedures or settings. The Plan is designed to encourage your awareness of the most cost-effective level of medical care that is appropriate for your needs. To enable your Plan to provide coverage in a cost-effective way, your Plan has adopted a utilization management program designed to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Trust Fund is better able to afford to maintain the Plan and all its benefits. If you follow the procedures of the Plan's utilization management program, you may avoid some out-of-pocket costs. However, if you don't follow these procedures, your Plan provides reduced benefits, and you'll be responsible for paying more out of your own pocket.

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

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

Elements of the Utilization Management Program: The Plan's Utilization Management Program consists of:

1. **Precertification/preauthorization (preservice) review**: review of proposed health care services before the services are provided;
2. **Concurrent (continued stay) review**: ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a hospital or health care facility or continued duration of healthcare services;
3. **Second Surgical Opinion**: consultation and/or examination designed to take a second look at the need for certain elective health care services;
4. **Retrospective (post-service) review**: review of health care services after they have been provided; and
5. **Case management**: a process whereby the patient, the patient's family, physician and/or other health care providers, and the Plan work together under the guidance of the Plan's independent Utilization Management Company to coordinate a quality, timely and cost-effective treatment plan. Case management services may be particularly helpful for individuals who require complex, high-technology medical services and who may therefore benefit from professional assistance to guide them through the maze of choices of health care services, providers and practices.

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

1. The fact that your Physician recommends Surgery, Hospitalization, confinement in a Health Care Facility, or that your Physician or other Health Care Provider proposes or provides any other medical services or supplies doesn't mean that the recommended services or supplies will be considered medically necessary for determining coverage under the Medical Plan.
2. The Utilization Management Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM Company's certification that a service is medically necessary doesn't mean that a benefit payment is guaranteed. Eligibility for and actual payment of benefits are subject to the terms and conditions of the Plan as described in this document. For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan either in whole or in part.
3. All treatment decisions rest with you and your Physician (or other Health Care Provider). You should follow whatever course of treatment you and your Physician (or other Health Care Provider) believe to be the most appropriate, even if:
   - the UM Company does not certify a proposed Surgery or other proposed medical treatment as medically necessary; or
   - the Plan will not pay regular Plan benefits for a Hospitalization or confinement in a Health Care Facility because the UM Company does not certify a proposed confinement; the benefits payable by the Plan may, however, be affected by the determination of the UM Company.
4. With respect to the administration of this Plan, the Trustees, the Claims Administrator and the UM Company are not engaged in the practice of medicine, and none of them takes responsibility either for the quality of health care services actually provided, even if they have been certified by the UM Company as medically necessary, or for the results if a person chooses not to receive health care services that have not been certified by the UM Company as medically necessary.

PRECERTIFICATION/PREAUTHORIZATION (PRESERVICE) REVIEW

How Precertification Review Works

Precertification Review is a procedure, administered by the UM Company, to assure that health care services meet or exceed accepted standards of care and that the admission and length of stay in a Hospital or Health Care Facility, Surgery, and other health care services are medically necessary. **The following services must be precertified (pre-approved) BEFORE the services are provided:**

WHAT SERVICES MUST BE PRECERTIFIED BY THE UTILIZATION MANAGEMENT COMPANY

All Elective (non-emergency) Hospital admissions and admissions for Behavioral Health services. Note: for pregnant women, precertification is required only for hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section.

How to Request Precertification (Pre-service Review)

It is your responsibility to assure that precertification occurs when it is required by this Plan. Any penalty for failure to precertify is on you, not the health care provider. You or your Physician must call the UM Company at the telephone number shown in the Quick Reference Chart in the front of this document.

1. **Calls for Elective services should be made at least 7 days before the expected date of service.**
2. The caller should be prepared to provide all of the following information: the employer's name, employee's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the name of any Hospital or outpatient facility or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. When calling to precertify, if the preservice review process was not properly followed the caller will be notified as soon as possible but not later than 5 calendar days after your request.
4. If additional information is needed, the UM Company will advise the caller. The UM Company will review the information provided, and will let you, your Physician and the Hospital or other Health Care Provider, and the Claims Administrator know whether or not the proposed health care services have been certified as medically necessary. The UM Company will usually respond to your treating Physician or other Health Care Provider **by telephone within 3 working days (but not later than 15 calendar days) after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.
5. If your admission or service is determined not to be medically necessary, you and your physician will be given recommendations for alternative treatment. You may also pursue an appeal. See the Claim Filing and Appeal Information chapter regarding appealing a UM determination.

CONCURRENT (CONTINUED STAY) REVIEW

How concurrent (continued stay) review works:

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

Emergency Hospitalization: If an emergency requires hospitalization, there may be no time to contact the UM Company before you are admitted. If this happens, the UM Company must be notified of the hospital admission within 24 hours. You, your physician, the hospital, a family member or friend can make that phone call. This will enable the UM Company to assist with discharge plans, determining the need for continued medical services, and/or advising your physician or other health care providers of the various recommendations, options and alternatives for your medical care.

SECOND SURGICAL OPINION

Under the **voluntary second opinion procedure** the Plan will pay for a second opinion consultation that you desire to have because of a proposed surgery or service. See the Schedule of Medical Benefits and the Second Surgical Opinion row for details.

CASE MANAGEMENT

How Case Management Works: Case management is a voluntary process, administered by the UM Company. Its medical professionals work with the patient, family, caregivers, health care providers, Claims Administrator and the Plan to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when an individual needs complex, costly, and/or high-technology services, and when assistance is needed to guide the individual through a maze of potential health care providers. See the section titled Restrictions and Limitations of the Utilization Management Program in this chapter.

Working with the Case Manager: Any Plan Participant, Physician, or other Health Care Provider can request Case Management services by calling the UM Company at the telephone number shown on the Quick Reference Chart in the front of this document. However, in most cases, the UM Company will be actively searching for those cases where the individual could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager of the UM Company will work directly with your Physician, Hospital, and/or other Health Care Facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from Health Care Providers as needed. From time to time, the Case Manager may confer with your Physician or other Health Care Providers and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Physician may call the Case Manager of the Utilization Management Company at any time at the telephone number shown on the Quick Reference Chart in the front of this document to ask questions, make suggestions, or offer information.

APPEALING A UM DETERMINATION (APPEALS PROCESS)

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

FAILURE TO FOLLOW REQUIRED UTILIZATION MANAGEMENT PROCEDURES (VERY IMPORTANT INFORMATION)

If you don't follow the Precertification Review, Concurrent (Continued Stay) Review, or Case Management procedures, the Claims Administrator may request a retrospective review to determine if the services performed or received were medically necessary.

1. If the UM Company determines that the services were **not medically necessary, no Plan benefits will be payable for those services.**
2. If the UM Company determines that the services **were medically necessary**, benefits payable by the Plan (for all services received that were subject to the Utilization Management review procedures and requirements set forth in this chapter that you did not follow) will be **reduced to a Coinsurance of 50%** rather than the usual coinsurance for such benefits.

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

MEDICAL PLAN EXCLUSIONS

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

GENERAL EXCLUSIONS (applicable to all medical services and supplies)

1. All medical or hospital services not specifically covered in, or which are limited or excluded by the plan documents.
2. **Autopsy:** Expenses for an autopsy and any related expenses.
3. **Costs of Reports, Bills, etc.:** Expenses for preparing medical reports, bills or claim forms; mailing, shipping or handling expenses; and charges for broken/missed appointments, telephone calls, interest charges, late fees, mileage costs, provider administration fees and/or photocopying fees.
4. **Educational Services:** Even if they are required because of an injury, illness or disability of a Participant, the following expenses are not payable by the Plan: educational services, supplies or equipment, including, but not limited to computers, software, printers, books, tutoring, visual aides, vision therapy, auditory aides, speech aids, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with sign language education for a patient or family members, and implantable medical identification/tracking devices.
5. **Employer-Provided Services:** Expenses for services rendered through a medical department, clinic or similar facility provided or maintained by your employer or the Trust Fund, or if benefits are otherwise provided under this Plan or any other Plan that your employer or the Trust Fund contributes to or otherwise sponsors, such as HMOs.
6. **Expenses Exceeding Maximum Plan Benefits:** Expenses that exceed any Plan benefit limitation, or Annual Maximum Plan Benefits as described in the Medical Expense Coverage chapter of this document.
7. **Expenses Exceeding Usual and Customary or Scheduled Charges:** Any portion of the expenses for covered medical services or supplies that are determined by the Plan Administrator or its designee to exceed the Usual and Customary Charge as defined in the Definitions chapter of this document.
8. **Expenses for Which a Third Party Is Responsible:** Expenses for services or supplies for which a third party is required to pay are not covered. See the provisions relating to Third Party Liability in the chapter on Coordination of Benefits in this document for an explanation of the circumstances under which the Plan will advance the payment of benefits until it is determined that the third party is required to pay for those services or supplies.
9. **Expenses Incurred Before or After Coverage:** Expenses for services rendered or supplies provided before the patient became covered under the medical program; or after the date the patient's coverage ends, except under those conditions described in the COBRA chapter of this document.
10. **Experimental and/or Investigational Services:** Expenses for any medical services, supplies, or drugs or medicines that are determined by the Plan Administrator or its designee to be Experimental and/or Investigational as defined in the Definitions chapter of this document, except for coverage for medically necessary routine patient care costs for members participating in a cancer clinical trial.
11. **Government-Provided Services (Tricare, VA, etc.):** Expenses for services when benefits for them are provided to the Participant under any plan or program (including, without limitation, Tricare and Veterans programs) established under the laws or regulations of any government, including the federal, state, or local government or the government of any other political subdivision of the United States, or of any other country or any political subdivision of any other country; **or** under any plan or program in which any government participates other than as an employer, unless the governmental program provides otherwise.
12. **Illegal Act:** Expenses incurred by any Participant for injuries resulting from or sustained as a result of commission, or attempted commission by the Participant, of an illegal act that the Plan Administrator determines in his or her sole discretion, on the advice of legal counsel, involves violence or the threat of violence to another person or in which a firearm, explosive or other weapon likely to cause physical harm or death is used by the Participant. The Plan Administrator's discretionary determination that this exclusion applies will not be affected by any subsequent official action or determination with respect to prosecution of the Participant (including, without limitation, acquittal, or failure to prosecute) in connection with the acts involved.
13. **Medically Unnecessary Services:** Services or supplies determined by the Plan Administrator or its designee not to be medically necessary as defined in the Definitions chapter of this document.

14. **Modifications of Homes or Vehicles:** Expenses for construction or modification to a home, residence or vehicle required as a result of an injury, illness or disability of a Participant, including, without limitation, construction or modification of ramps, elevators, hand rails, chair lifts, spas/hot tubs, air conditioning, dehumidification devices, asbestos removal, air filtration/purification, swimming pools, emergency alert system, etc.
15. **No-Cost Services:** Expenses for services rendered or supplies provided for which a Participant is not required to pay or which are obtained without cost, or for which there would be no charge if the person receiving the treatment were not covered under this Plan.
16. **Services Not Prescribed by a Physician**: Expenses for services rendered or supplies provided that are not recommended or prescribed by a Physician, except for covered services provided by a Behavioral Health Practitioner, Certified Nurse Midwife, Nurse Practitioner, Physician Assistant, Chiropractor, Dentist, or Podiatrist.
17. **Non-Emergency Travel and Related Expenses:** Expenses for and related to non-emergency travel or transportation (including lodging, meals and related expenses) of a Health Care Provider, Participant or family member of a Participant.
18. **Occupational Illness, Injury or Conditions Subject to Workers' Compensation:** All expenses incurred by you or any of your covered Dependents arising out of or in the course of employment (including self-employment) if the injury, illness or condition is subject to coverage, in whole or in part, under any workers' compensation or occupational disease or similar law, whether or not any such claim was made.
19. **Personal Comfort Items:** Expenses for patient convenience, including, but not limited to, care of family members while the Participant is confined to a Hospital or other Health Care Facility or to bed at home, guest meals, television, VCR/DVD, telephone, barber or beautician services, house cleaning or maintenance, shopping, birth announcements, photographs of new babies, etc.
20. **Physical Examinations, Tests for Employment, School, etc.:** Expenses for physical examinations and testing required for employment, government or regulatory purposes, insurance, school, camp, recreation, sports, or by any third party.
21. **Private Room in a Hospital or Health Care Facility:** The use of a private room in a Hospital or other Health Care Facility, unless the facility has only private room accommodations or unless the use of a private room is certified as medically necessary by the Plan Administrator or its designee.
22. **Relatives Providing Services:** Expenses for services provided by any Physician or other Health Care Practitioner who is the parent, spouse, sibling (by birth or marriage) or child of the patient or Member.
23. **Medical Students, Interns or Residents:** Expenses for the services of a medical student, intern or resident.
24. **Telephone Calls:** Expenses for any and all telephone calls between a Physician or other Health Care Provider and any patient, other Health Care Provider, Utilization Management Company, or any representative of the Plan for any purpose whatsoever, including, without limitation: communication with any representative of the Plan or its Utilization Management Company for any purpose related to the care or treatment of a Participant, consultation with any Health Care Provider regarding medical management or care of a patient; coordinating medical management of a new or established patient; coordinating services of several different health professionals working on different aspects of a patient's care; discussing test results; initiating therapy or a plan of care that can be handled by telephone; providing advice to a new or established patient; providing counseling to anxious or distraught patients or family members.
25. **Internet/Virtual Office/Telemedicine Services:** Expenses related to an online internet consultation with a Physician or other Health Care Practitioner, also called a virtual office visit/consultation, physician-patient web service or physician-patient e-mail service, or telemedicine (real-time or store and forward types) telehealth, e-health, remote diagnosis and treatment, real-time video-conferencing including receipt of advice, treatment plan, prescription drugs or medical supplies obtained from an online internet provider.
26. **Self-Inflicted Injury or Attempted Suicide:** Expenses incurred by any Participant arising from an attempt at suicide or from a self-inflicted injury or illness, including complications thereof, unless the attempt arises as a result of a physical or mental health condition.
27. **Hospital confinement which precedes elective surgery** by more than 24 hours unless surgery is delayed by reason of medical necessity or the admission occurs between noon on Friday and noon on the following Sunday unless medically necessary.

EXCLUSIONS APPLICABLE TO SPECIFIC MEDICAL SERVICES AND SUPPLIES

A. Alternative/Complementary Health Care Services Exclusions

1. Expenses for acupuncture and/or acupressure.
2. Expenses for chelation therapy, except as may be medically necessary for treatment of acute arsenic, gold, mercury or lead poisoning, and for diseases due to clearly demonstrated excess of copper or iron.
3. Expenses for prayer, religious healing, or spiritual healing except services provided by a Christian Science Practitioner.
4. Expenses for naturopathic, naprapathic and/or homeopathic services or treatments/supplies.

5. Expenses for massage therapy, rolfing (deep muscle manipulation and massage), hellerwork (deep tissue bodywork) craniosacral therapy (noninvasive rhythmic manipulation of the craniosacral areas) and related services.

B. Chelation therapy except for acute arsenic, gold, mercury or lead poisoning.

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

1. Expenses for any items that are **not** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment as each of those terms is defined in the Definitions chapter of this document, including but not limited to air purifiers, swimming pools, spas, saunas, escalators, lifts, motorized modes of transportation, pillows, mattresses, water beds, and air conditioners.
2. Expenses for **replacement of lost, missing, or stolen**, **duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.
3. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.
4. Expenses for occupational therapy **(orthotic) supplies and devices** needed to assist a person in performing activities of daily living including self-help devices such as feeding utensils, reaching tools and devices to assist in dressing and undressing.
5. Expenses for **nondurable supplies,** except as payable under Nondurable Supplies in the Schedule of Medical Benefits.

D. Cosmetic Services Exclusions

1. Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to removal of tattoos, breast reduction, elimination of redundant skin of the abdomen, or other medical or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The Medical Program **does** cover medically necessary Reconstructive Services. To determine the extent of this coverage, see Reconstructive Services in the Schedule of Medical Benefits. Plan Participants should use the Plan's Precertification procedure to determine if a proposed surgery or service will be considered Cosmetic Surgery or medically necessary Reconstructive Services.

E. Custodial Care Exclusions

1. Expenses for Custodial Care as defined in the Definitions chapter of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service, except when Custodial Care is provided as part of a covered Hospice program or is provided during a covered hospitalization.
2. Services required to be performed by Physicians, Nurses or other skilled Health Care Providers are **not** considered to be provided for Custodial Care services and are covered if they are determined by the Plan Administrator or its designee to be medically necessary. However, any services that can be learned to be performed or provided by a family member who is not a Physician, Nurse or other skilled Health Care Provider are **not covered**, even if they are medically necessary.

F. Dental Services Exclusions

1. Expenses for Dental services or supplies of any kind, (even if they are necessary because of symptoms, congenital anomaly, illness or injury affecting the mouth or another part of the body) including but not limited to dental x-rays, dental prosthetics and dental services for the care, filling, removal or replacement of teeth, or the treatment of injuries to or disease of the teeth, gums or structures directly supporting or attached to the teeth. Expenses for Dental services may be covered under the Medical Plan if they are incurred for the repair or replacement of Accidental Injury to Teeth or restoration of the jaw if damaged by an external object in an accident. For the purposes of this coverage by the Plan, an accident does not include any injury caused by biting or chewing. See Oral, Craniofacial and TMJ Services in the Schedule of Medical Benefits to determine if those services are covered.
2. Expenses for Orthognathic services/surgery for treatment of aesthetic malposition of the bones of the jaw such as with Prognathism, Retrognathism and TMJ and other cosmetic reasons.
3. Expenses for oral surgery to remove teeth including wisdom teeth, gingivectomies, treatment of dental abscesses, root canal (endodontic) therapy except those oral surgery services listed as payable under the Oral and Craniofacial section of the Schedule of Medical Benefits.

G. Drugs, Medicines and Nutrition Exclusions

1. Pharmaceuticals requiring a prescription that have not been approved by the US Food and Drug Administration (FDA); or are not approved by the FDA for the condition, dose, route and frequency for which they are prescribed (*i.e.* are used "off-label"); or are Experimental and/or Investigational as defined in the Definitions chapter of this document.
2. Non-prescription (or non-legend or over-the-counter) drugs or medicines, except insulin.

3. Foods and nutritional supplements including, but not limited to, home meals, formulas, foods, diets, vitamins, herbs and minerals (whether they can be purchased over-the-counter or require a prescription), except foods and nutritional supplements provided during covered hospitalization and prenatal vitamins or minerals requiring a prescription.
4. Medical Foods (as defined in the Definitions chapter of this document).
5. Naturopathic, naprapathic or homeopathic services and substances.
6. Drugs, medicines or devices for:
   - non-prescription contraceptives;
   - fertility and/or infertility;
   - the arthritis medication called Enbrel;
   - hair removal or hair growth products (*e.g.,* Propecia, Rogaine, Minoxidil, Vaniqa);
   - growth hormone;
   - tobacco/smoking cessation;
   - weight control or anorexiants (*e.g.,* Meridia, Xenical).
7. Compounded prescriptions in which there is not at least one ingredient that is a legend drug requiring a prescription as defined by federal or state law.
8. Self-help devices such as a scale, pill crusher, magnifying glass/device, etc.
9. Prescriptions filled at a non-contracted (out-of-network) retail pharmacy or mail order service.

H. Durable Medical Equipment Exclusions

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

I. Fertility and Infertility Services Exclusions

1. Expenses for the diagnosis and treatment of infertility along with 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, cryostorage of egg or sperm, adoption, ovarian transplant, infertility donor expenses, fetal implants, fetal reduction services, surgical impregnation procedures and reversal of sterilization procedures. Except as listed in the Schedule of Benefits.

J. Foot/Hand Care Exclusions

1. Expenses for routine foot care, (including but not limited to trimming of toenails, removal or reduction of corns and callouses, removal thick/cracked skin on heels, foot massage, preventive care with assessment of pulses, skin condition and sensation) or hand care including manicure and skin conditioning, unless the Plan Administrator or its designee determines such care to be medically necessary. Routine foot care from a podiatrist is payable for individuals with diabetes or a neurological or vascular insufficiency affecting the feet.

K. Hair Exclusions

1. Expenses for and related to hair removal or hair transplants and other procedures to replace lost hair or to promote the growth of hair, including prescription and non-prescription drugs such as Minoxidil, Propecia, Rogaine, Vaniqa; or expenses for and related to hair replacement including, but not limited to, devices, wigs, toupees and/or hairpieces or hair analysis, except that the Plan will provide benefits for a single wig, toupee or hairpiece if it is required to replace hair lost as a result of chemotherapy or alopecia, payable to a maximum of $500/person /lifetime.

L. Hearing Care Exclusions

1. Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices, including, implantable hearing devices such as cochlear implants.

M. Home Health Care Exclusions

1. Expenses for any Home Health Care services **other than** part-time, intermittent **skilled nursing** services and supplies, such as a homemaker, custodial care, childcare, adult care or personal care attendant.

N. Immunizations for travel or work except where medically necessary or indicated

O. Implantable drugs and certain injectable infertility drugs

P. Long-term rehabilitation therapy

Q. Maternity/Family Planning/Contraceptive Exclusions

1. Expenses related to non-prescription contraceptive drugs and devices such as condoms. No coverage for contraceptives for dependent children unless determined to be medically necessary by the Plan Administrator or its designee.
2. Expenses for **childbirth education, Lamaze classes, breast-feeding** classes.
3. Expenses related to the **maternity care and delivery expenses associated with a pregnant dependent child or surrogate mother's pregnancy.**
4. Home births.
5. Expenses related to **cryostorage of umbilical cord blood or other tissue or organs.**

R. For Nondurable supplies (see Corrective Appliances)

S. Nursing Care Exclusions

1. Expenses for services of private duty nurses.

T. Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

1. Expenses for educational, job training, vocational rehabilitation.
2. Expenses for massage therapy, rolfing (deep muscle manipulation and massage), hellerwork (deep tissue bodywork) craniosacral therapy (noninvasive rhythmic manipulation of the craniosacral areas) and related services.
3. Expenses for Maintenance Rehabilitation as defined under Rehabilitation in the Definitions chapter of this document.
4. Expenses for speech therapy for functional purposes including, but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering and conditions of psychoneurotic origin or for childhood developmental speech delays and disorders.
5. Expenses for treatment of delays in childhood speech development unless as a direct result of an injury, surgery or result of a covered treatment.

U. Reversal of sterilization

V. Sex Change Services Exclusions

1. **Sex Change Counseling, Therapy and Surgery:** Expenses for medical, surgical or prescription drug treatment related to transsexual/gender reassignment (sex change) procedures, or the preparation for such procedures, or any complications resulting from such procedures except as determined to be Medically Necessary by the Trust Fund.

The Plan will cover medically necessary transgender healthcare services for Gender Dysphoria. **It is highly recommended that your service provider submit information to the Plan for a coverage determination prior to receiving any services.**:

Transgender healthcare services considered medically necessary to treat Gender Dysphoria may include:

- Mental health counseling/therapy
- Hormone therapy
- Gender reassignment surgery
- Services typically associated with one sex, which may continue to be required after a transition, including breast cancer screening (female to male transition) or prostate cancer screening (male to female transition.)

To be eligible for coverage you must:

- Be 18 years of age or older,
- Have a well-documented diagnosis of Gender Dysphoria or Gender Identity Disorder meeting the diagnostic criteria of the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), and
- In the event of gender reassignment surgery, have no medical contraindications and complete specific evaluation and recommendation requirements.

The Plan does not cover services that are considered cosmetic, not medically necessary and/or are otherwise excluded under the Plan. This includes, but is not limited to:

- Rhinoplasty or nose implants
- Face-lifts
- Lip enhancement or reduction
- Facial bone reduction or enhancement
- Blepharoplasty (eyelid surgery)

- Breast Augmentation
- Liposuction
- Reduction thyroid chondroplasty (Adam's Apple reduction)
- Hair removal (Exception: Hair removal procedures (including electrolysis) may be considered medically necessary to treat tissue donor sites prior to phalloplasty or vaginoplasty.)
- Voice modification surgery or training
- Skin resurfacing
- Travel expenses

The Plan will cover gender reassignment surgery when it is medically necessary and all of the following criteria are met:

- The individual is at least 18 years of age; and
- The individual has capacity to make fully informed decisions and consent for treatment; and
- The individual has been diagnosed with gender dysphoria and exhibits all of the following:
    - The desire to live and be accepted as a member of the opposite sex, usually accompanied by the wish to make his or her body as congruent as possible with the preferred sex through surgery and hormone treatment; and
    - The transsexual identity has been present persistently for at least two years; and
    - The disorder is not a symptom of another mental disorder; and
    - The disorder causes clinically significant distress or impairment in social, occupational, or other important areas of functioning; and
- For individuals without a medical contraindication, the individual has undergone a minimum of 12 months of continuous hormonal therapy when recommended by a mental health professional and provided under the supervision of a physician; and
- Documentation that the individual has completed a minimum of 12 months of successful continuous full-time real-life experience in their new gender, across a wide range of life experiences and events that may occur throughout the year (for example, family events, holidays, vacations, season-specific work or school experiences). This includes coming out to partners, family, friends, and community members (for example, at school, work, and other settings); and
- Regular participation in psychotherapy throughout the real-life experience when recommended by a treating medical or behavioral health practitioner; and
- If the individual has significant medical or mental health issues present, they must be reasonably well controlled. If the individual is diagnosed with severe psychiatric disorders and impaired reality testing (for example, psychotic episodes, bipolar disorder, dissociative identity disorder, borderline personality disorder), an effort must be made to improve these conditions with psychotropic medications and/or psychotherapy before surgery is contemplated; and
- Two referrals from qualified mental health professionals who have independently assessed the individual. If the first referral is from the individual's psychotherapist, the second referral should be from a person who has only had an evaluative role with the individual. Two separate letters, or one letter signed by both (for example, if practicing within the same clinic) are required. The letter(s) must have been signed within 12 months of the request submission.

Sex reassignment surgery is considered not medically necessary when one or more of the criteria above have not been met.

Services and Procedures that are considered Cosmetic and used to improve the gender specific appearance of an individual who has undergone or is planning to undergo sex reassignment surgery are not medically necessary and therefore not covered by the Plan. Autologous tissue flap breast reconstructions are considered not medically necessary for gender reassignment surgery. Any services performed to reverse gender reassignment surgery are not covered by the Plan.

W. Transplant (Organ and Tissue) Exclusions

1. Expenses related to non-human (Xenografted) organ and/or tissue transplants or implants, except heart valves.
2. Donor expenses unless the person who receives the donated organ/tissue is a person covered by this Plan.

X. Vision Care Exclusions

1. Expenses for surgical correction of refractive errors and refractive keratoplasty procedures including, but not limited to, Radial Keratotomy (RK) and Automated Keratoplasty (ALK), or Laser In-Situ Keratomileusis (LASIK).
2. Expenses for diagnosis and treatment of refractive errors, including eye examinations, purchase, fitting and repair of eyeglasses (frames or lenses) and associated supplies.
3. Vision therapy (orthoptics) and supplies.

Y. Weight Management and Physical Fitness Exclusions

1. Expenses for medical or surgical treatment of obesity or morbid obesity, including, but not limited to, drug therapy, gastric restrictive procedures, gastric or intestinal bypass, reversal of a previously performed weight management surgery, weight loss programs, dietary instructions, and any complications thereof, even if those procedures are performed to treat a comorbid or underlying health condition
2. Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, work hardening and/or weight training services.

MEDICAL BENEFITS - CENTRAL COAST PARTICIPANTS

Central Coast participants are covered by the Aetna PPO plan as outlined on pages 27-30

KAISER HMO HEALTH COVERAGE

New Participants, except for certain designated Participants in San Joaquin County as explained below, will automatically be enrolled in the Self-Funded Indemnity Plan (which includes a PPO) and will remain in the Self-Funded Plan until the next regularly scheduled Open Enrollment Period. At the next regularly scheduled Open Enrollment Period, usually held during the month of November, those eligible for the Self-Funded Plan benefits will have the opportunity to remain in the Self-Funded Plan or select the HMO options offered by the Trust Fund. Those already in the HMO Plan may choose to remain in that HMO Plan or may choose to enroll in the Self-Funded Plan, if applicable.

The HMO option is the Kaiser HMO. In order to enroll in the HMO option, you and your Dependents, if any, must reside within the applicable service area served by that particular HMO. Benefit summaries outlining the Plan of Benefits for each of the HMO's are provided on the following pages.

The Plan you select will apply to you and all of your Dependents. If you choose HMO coverage, a separate booklet will be provided which explains the terms and conditions of the HMO Plan in more detail.

You may change your coverage option only during the annual Open Enrollment Period. If you change your option during the Open Enrollment Period, your new option will become effective on the first day of January provided your completed application form has been received by the Administration Office.

Certain designated Participants who are employed by the Marriott Hotel in Visalia, San Joaquin County will automatically become Participants in the Self-Funded PPO Plan offered specifically for that group of Participants. That group will become initially eligible for the Self-Funded PPO Plan and will remain in the Self-Funded PPO Plan. This group of Participants will not be offered the annual Open Enrollment opportunity.

The following is only a summary of benefits. For more information about your coverage, or to get a copy of the complete terms of coverage see www.kp.org/plandocuments or 1-800-278-3296.

Kaiser Health Plan – Traditional Plan

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Deductible or Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Routine preventative care:	
Physical exams	No Charge
Well-child visits (through age 23 months)	No Charge
Scheduled prenatal care visits and first postpartum visit	No Charge
Family planning visits	$10 per visit
Eye refraction exams	$10 per visit
Hearing tests	$10 per visit
Primary and specialty care visits	$10 per visit
Urgent care visits	$10 per visit
Physical, occupational, and speech therapy	$10 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injection visits	$3 per visit
Allergy testing visits	$10 per visit
Vaccines (immunizations)	No charge
X-rays and lab tests	No charge
Health Education:	
Individual visits	$10 per visit
Group educational programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No Charge

Emergency Health Coverage	You Pay
Emergency Department visits – applies to both Kaiser and non-Kaiser facilities	$50 per visit (does not apply if admitted directly to the hospital as an inpatient)
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
The outpatient prescription drugs listed in the "Benefits and Cost Sharing" section in accord with our drug formulary guidelines from Plan Pharmacies or from our mail order service (most outpatient prescription drugs are **not covered**)	Generic: $10/30-day Retail prescription Generic: $20/100-day Mail order prescription Brand: $20/30-day Retail prescription Brand: $40/100-day Mail order prescription Specialty: $20/30-day Retail prescription
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	$250 per admission
Outpatient visits	$10 per individual visit $5 per group visit
Mental Health Services	
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the "Benefits and Cost Sharing" section.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Outpatient individual visits	$10 per visit
Outpatient group visits	$5 per visit
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	$100 per admission
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge
Other	**You Pay**
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
Hospice care	No charge

Kaiser Health Plan – Deductible Plan

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$3,000 per calendar year
For any one Member in a Family of two or more Members	$3,000 per calendar year
For an entire Family of two or more Members	$6,000 per calendar year
Lifetime Maximum	None
Deductible	
Generally, you must pay all of the costs from providers up to the deductible amount before this plan begins to pay. If you have other family members on the plan, each family member must meet their own individual deductible until the total amount of deductible expenses paid by all family members meets the overall family deductible.	
Individual	$500
Family	$1,000
Professional Services (Plan Provider office visits)	**You Pay**
Routine preventative care:	
Physical exams	No charge; deductible does not apply
Well-child visits (through age 23 months)	No charge; deductible does not apply
Scheduled prenatal care visits and first postpartum visit	No charge; deductible does not apply
Family planning visits	$20 per visit; deductible does not apply
Eye refraction exams	$20 per visit; deductible does not apply
Hearing tests	$20 per visit; deductible does not apply
Primary and specialty care visits	$20 per visit; deductible does not apply
Urgent care visits	$20 per visit; deductible does not apply
Physical, occupational, and speech therapy	$20 per visit; deductible does not apply

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	20% Coinsurance
Allergy injection visits	$20 per visit; deductible does not apply
Allergy testing visits	$20 per visit; deductible does not apply
Vaccines (immunizations)	No charge; deductible does not apply
X-rays and lab tests	$10 per encounter
Health Education:	
Individual visits	$20 per visit; deductible does not apply
Group educational programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	20% Coinsurance
Emergency Health Coverage	**You Pay**
Emergency Department visits	20% Coinsurance
Ambulance Services	**You Pay**
Ambulance Services	$150 per trip
Prescription Drug Coverage	**You Pay**
The outpatient prescription drugs listed in the "Benefits and Cost Sharing" section in accord with our drug formulary guidelines from Plan Pharmacies or from our mail order service (most outpatient prescription drugs are **not covered**)	Generic: $10/prescription up to 100 days Brand: $30/prescription up to 100 days after $100 drug deductible Specialty: $30/prescription up to 30 days after $100 drug deductible
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	20% Coinsurance
Outpatient visits	$20 per visit; deductible does not apply
Mental Health Services	
Note: Visit and day limits do not apply to serious emotional disturbances of children and severe mental illnesses as described in the "Benefits and Cost Sharing" section.	
Chemical Dependency Services	**You Pay**
Inpatient detoxification	20% Coinsurance
Outpatient individual visits	$20 per visit; deductible does not apply
Outpatient group visits	$20 per visit; deductible does not apply
Transitional residential recovery Services (up to 60 days per calendar year, not to exceed 120 days in any five-year period)	20% Coinsurance
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge; deductible does not apply
Other	**You Pay**
Skilled Nursing Facility care (up to 100 days per benefit period)	20% Coinsurance
Hospice care	No charge; deductible does not apply

KAISER HMO HEALTH COVERAGE - CENTRAL COAST PARTICIPANTS

Central Coast participants do not have access to the Kaiser HMO plan due to network restrictions.

VISION EXPENSE COVERAGE

OVERVIEW OF THE INSURED VISION PLAN

If you are eligible for the Medical Plan benefits you are also eligible to enroll in the Vision Plan benefits. The Vision Plan is designed to provide for regular vision examinations and benefits toward eyeglasses or contact lenses. The Vision Plan contracts with a national network of vision providers who extend a discount to you for covered vision services. Covered expenses are noted in the Schedule of Vision Benefits in this chapter and refer to the usual, customary and reasonable charge for covered services up to the maximum allowed as payable under this Vision Plan.

VISION NETWORK PROVIDERS

As part of its cost containment effort, the Vision Plan provides a voluntary Preferred Provider Organization (PPO) option where special rates which have been negotiated with certain Vision Providers (called Preferred Vision Providers, In-Network Providers or PPO Providers). These special discounted rates save you money because the lower fees mean you and your covered dependents pay less money out of your pocket.

You may go to any Vision Provider (licensed ophthalmologist, optometrist or dispensing optician); however, this freedom of choice may cost you a great deal of money even with the benefits provided under this Plan. You may either choose to use a PPO Vision Provider and SAVE MONEY because of the discount those PPO providers offer to Plan participants or, you may choose any non-PPO Vision Provider. The Plan will pay an allowed amount of money toward the non-discounted bill of a non-PPO vision provider, but you will have to pay the balance of the bill that is not payable by this Plan.

It is your responsibility to confirm that your Vision Provider is a participant in the PPO Network. Additions and changes to the Vision PPO membership list are made continuously, and revised directories are published regularly. A current list of network vision providers is available when you call the Vision Plan whose name, address and telephone number are listed on the Quick Reference Chart in the front of this document.

To receive services, simply call a network vision provider and identify yourself as a member of this Vision Plan.

HOW DOES THE IN-NETWORK VISION BENEFIT WORK?

- **Step One:** When you are ready to obtain vision care services call an In-Network Vision Provider. The list of participating vision providers is available from the Vision Plan Administrator whose name, phone number and website are listed on the Quick Reference Chart in the front of this document.
- **Step Two**: When making an appointment, please identify tell the provider that you are a member of the vision plan network. You will need to give the provider your ID number (usually your social security number) and the group name (the name of this Trust Fund). The In-Network Vision Provider will be able to verify your eligibility and benefits by contacting the Vision Plan Administrator.
- **Step Three**: At your appointment the In-Network Vision Provider will provide an eye examination and determine if eyewear is necessary. If so, the provider will coordinate the prescription for eyewear with an approved vision laboratory. The provider will itemize any non-covered charges and have you sign a form to document that you received services. The Vision Plan Administrator will pay the Vision provider directly for covered services and materials. You are responsible for paying the provider any copayment and any additional costs associated with non-covered or cosmetic services/materials you selected.

DEFINITION OF TERMS USED IN THIS VISION PLAN

- A **vision exam** includes a professional examination and an eye refraction including case history, exam for pathological abnormalities of the eyes and lids, ranges of clear single vision and balance and coordination of muscles for far-seeing and near-seeing and special working distances.
- **Dispensing optician** means a person qualified to manufacture and sell eyeglasses and/or contact lenses.
- **Optometrist** is a person licensed to practice optometry (the science of diagnosing, managing and treating eye and visual diseases).
- **Ophthalmologist** is a physician licensed to practice ophthalmology (treatment of diseases of the eye).

SCHEDULE OF VISION BENEFITS

This chart shows what the Plan pays.

Covered Vision Benefits	Explanations and Limitations *See also the Vision Plan Exclusions section.*	Plan Pays	
		In-Network Provider	**Non-Network Provider**
Vision Eye Examination *without* contact lens fitting.	• One vision exam is payable once each 12 months.	100% after a $20 copay per exam In-network providers offer a 15% discount off their fee for contact lens fitting and evaluation when provided by the same in-network provider who did the eye exam within the last 12 months.	100%, not to exceed $40 per exam.
Frames for Eyeglasses • The Plan covers a wide range of frames but not all frames will be covered in full. If you select a frame that exceeds the Plan's allowance these added charges will be yours to pay.	• One frame is payable each 24 months. • Not also that the Vision Plan In-Network providers will extend a discount on non-covered prescription glasses. This benefit is valid for 12 months following the eye exam date. • You may choose contact lenses instead of eyeglasses. See the row below on Contacts.	100% up to the Plan allowance of $120.	100%, to $45.
Lenses for Eyeglasses	• A single vision, bifocal, trifocal or lenticular lens is payable once each 12 months. • Standard lenses are covered meaning, CR-39 basic plastic or white (clear) glass lenses. • No coverage for special coatings or tints on lenses, except that effective Jan 1, 2005 polycarbonate lenses are payable for children.	100% up to the Plan allowance Note that in-network providers will extend a discount of up to 20% for certain lens "extras" such as scratch resistant, anti-reflective coatings and progressive lenses.	Single Vision: 100%, up to $40. Lined Bifocals: 100%, up to $60. Lined Trifocals: 100%, up to $80. Lenticular: 100%, up to $125. If only one lens is needed, the allowance will be one-half the pair allowance.
Low Vision Benefit • The low vision benefit is available if you have severe visual problems that are not correctable with regular lenses and is subject to prior approval by the Vision Plan Administrator.		Supplemental Testing: 100% Supplemental Care: The Plan pays 75% of the cost to a maximum benefit of $1,000 every two years, excluding copayments.	You pay the difference between what the provider bills and what is payable by the Vision Plan had you used an in-network provider.

SCHEDULE OF VISION BENEFITS This chart shows what the Plan pays.			
Covered Vision Benefits	**Explanations and Limitations** *See also the Vision Plan Exclusions section.*	**Plan Pays**	
		In-Network Provider	**Non-Network Provider**
Contact Lenses: Medically (visually) necessary contact lenses are payable for the following reasons: • Following cataract surgery; or • Visual acuity cannot be improved to at least 20/70 in the better eye even with the use of eyeglasses. • With certain eye conditions such as anisometropia or keratoconus. Contact lenses that do not meet the above criteria are considered "not medically necessary" or elective.	• One set of medically necessary contact lenses are payable each 12 months in lieu of all other lens and frame benefits. If you elect contact lenses instead of eyeglasses you will be eligible for a frame 24 months after the date you last obtained the contact lenses. • One set of not medically necessary contact lenses are payable in lieu of eyeglasses. • You may use your annual contact lens allowance toward permanent and/or disposable lenses. • Note also there is a discount on the In-Network vision provider's professional fees when you purchase prescription contact lenses. This benefit is valid for 12 months following the eye exam date. • The participant is to pay the difference between the cost of contact lenses and the amount allowed under this Vision Plan.	*Cosmetic Lenses (not medically necessary):* After a $20.00 copay, the Plan pays 100% up the Plan Allowance of $105 per eye. *Contact Lenses (medically necessary):* After a $20 copay the Plan pays 100% up to the Plan Allowance	*Cosmetic Lenses (not medically necessary):* 100%, up to $105 per pair. *Contact Lenses (medically necessary):* 100%, up to $210 per pair.

VISION PLAN EXCLUSIONS

The Vision Plan is designed to cover visual needs rather than cosmetic materials. When a Participant selects any of the following extras, the Vision Plan will pay the cost of the allowed vision service/supply and the Participant will pay the additional cost for the extras, such as:

1. Blended lenses, oversized lenses (larger than 61mm), photochromic lenses (changes color with intensity of sunlight), progressive multifocal lenses, coated lenses, laminated lenses, cosmetic lenses such as tinted lenses (addition of substance to produce a color such as pink or green, etc.), sunglasses (plain or prescription), plano (non-prescription/less than .38 diopter power), UV(ultraviolet) protected lenses.
2. Vision services and supplies (such as a frame) that cost more than the Plan's allowance as noted in the Schedule of Vision Benefits.
3. Certain Low Vision Care services as outlined in the Schedule of Vision Benefits.
4. Orthoptics (vision training to improve the visual perception and coordination of the two eyes) and any associated supplemental testing.
5. Lenses and frames furnished under this program, which are lost or broken, will not be replaced except at the normal intervals when services are otherwise available as described in the Schedule of Vision Benefits.
6. Eye examinations or eyewear required as a condition of employment.
7. Two pair of lenses or eyeglasses in lieu of bifocals.
8. Medical or surgical treatment of the eyes, including, but not limited to, refractive keratoplasty (RK) or laser assisted in situ keratoplasty (LASIK), PRK. (Note that while these services are not payable by the plan In-Network providers may extend a discount to you for laser vision correction).
9. Glasses secured when there is no prescription charge, such as reading glasses obtained from a drugstore.
10. Services or materials provided as a result of any Workers' Compensation Law, or similar occupational health legislation or obtained through or required by any government agency or program, whether federal, state or any subdivision thereof.
11. Services or supplies received for an illness that is a result of war, whether declared or undeclared.
12. Vision check-ups or screenings requested by the participant's employer, school or government.
13. Treatment received from a medical department maintained by an employer, a mutual benefit association, a labor union, a trustee or a similar type group.
14. Experimental and/or investigational treatment or procedure.
15. Any service or material provided by any other vision care plan or group benefit plan containing benefits for vision care.

16. Benefits incurred beyond the termination date of the Plan, unless COBRA coverage is in place.
17. Orthokeratology lenses for reshaping the cornea of the eye to improve vision.

FILING A VISION CLAIM/APPEALING A DENIED CLAIM

When you use the services of an in-network vision provider, you should pay the provider only for your copay and those services not covered by the Vision Plan. The provider will typically send the remainder of their bill directly to the Vision Plan Administrator for reimbursement.

WHAT TO DO IF YOU USE A NON-NETWORK VISION PROVIDER?

Follow these steps if you use a non-network vision provider:

1. Pay the vision provider the full amount for the services they provided and request a copy of the bill that shows the amount for the eye examination, lens type, frame and other services.
2. Send the following information to the Vision Plan Administrator, whose address is listed on the Quick Reference Chart in the front of this document:
   - a copy of the itemized bill (using a HCFA 1500 form or any generic insurance claims for)
   - the member's name and mailing address,
   - member's ID number or Social Security number,
   - member's employer or group name and
   - patient's name, relationship to the member and date of birth.
3. **Claims must be submitted within 6 months of the date of the service** in order to be considered for reimbursement. You will be reimbursed up to the amount allowed under the Vision Plan as noted in the Schedule of Vision Benefits. Vision claims submitted beyond 6 months of the date of service may not be considered for reimbursement.
4. Your appeal of any denied vision claims should also be submitted to the Vision Plan Administrator.

DENTAL PLAN OPTIONS

The Plan provides dental care through an insured arrangement with MetLife. You can only change your dental plan option during the annual open enrollment. Eligible members have a choice between two dental plans. ***You are only eligible to elect the MetLife PPO Plan if you had hours reported prior to December 2015, you have completed the New Hire 24-month enrollment requirement in the MetLife Dental DHMO plan, or there is not a MetLife DHMO dentist within a 10-mile radius of your home address.*** Additional details are included in the enclosed MetLife Dental Benefits Summary.

- MetLife Dental PPO - Group #151059
- MetLife Dental DHMO - Group #151059

Separate booklets for these benefits are available from the Plan Office which describe this coverage. The Plan Office phone number is (800) 544-5085.

Below is a summary of the dental benefits. For complete details on your dental benefit coverage, please refer to the MetLife Evidence of Coverage Booklets. The Evidence of Coverage Booklets are the binding document between the Dental Plan and its Participants.

Summary of Insured MetLife Dental PPO Plan Benefits		
	In-Network	**Out-of-Network**
Reimbursement	Negotiated Fee Schedule	90th Percentile of Reasonable and Customary
Type A - Preventive	100%	100%
Type B - Basic	80%	50%
Type C - Major	60%	50%
Calendar Year Deductible applies to:	Type B & C	Type B & C
• **Individual**	$50	$50
• **Family**	$150 Aggregate	$150 Aggregate
Calendar Year Maximum (applies to A, B, C services)	$1,500	$1,500
Orthodontia	50%	50%
Orthodontia Lifetime Maximum	$1,000	$1,000

SUMMARY OF INSURED METLIFE DHMO

How the MetLife DHMO Program Works
The MetLife option provides comprehensive dental coverage and is designed like a medical HMO, meaning that you must use a MetLife network dentist. Care under this plan is provided through a network of Selected General Dentists. Your Selected General Dentist is responsible for determining when the services of a Specialty Care Dentist are needed and facilitating any necessary referral.

1. Choice of Provider

If you choose the MetLife DHMO Program, you and each covered family member must select and use a MetLife dentist. Each family member can choose a different dentist, but they must be located at the same MetLife facility. You will automatically receive a listing of the MetLife dental offices in your area when you first become eligible for coverage and you may log on at www.metlife.com/mybenefits for any updates to the listing.

2. Payment Provisions

Under the MetLife DHMO option, there is no annual deductible and benefits are paid at 100% for most preventive and diagnostic care services. A copayment may be required for routine care and major care.

What the DeltaCare Options Covers
Please refer to the MetLife Evidence of Coverage, ("EOC") which is available from the Administrator's Office.

What the MetLife DHMO Program Does Not Cover
Please refer to the MetLife EOC for the Plan exclusions and limitations. Plan booklets are also available at the Administrator's Office.

CLAIM FILING AND APPEAL INFORMATION

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The claims procedures outlined in this chapter will **afford you a full, fair and fast review of the claim to which it applies**. It is the intent of the Plan that the rules for claim processing and appeals be in compliance with 29 CFR 2560.503, as amended.

This chapter also discusses the process the Plan (described in this document) undertakes on **certain appealed claims, to consult with a Health Care Professional** with appropriate training and experience when reviewing an adverse benefit determination that is based in whole or in part on a medical judgment (such as a determination that a service is not medically necessary, is experimental or investigational). If you are enrolled in a Health Maintenance Organization (HMO) or benefit that is administered by an insurance company (since such benefits are not described in detail in this document), for information on filing claims or appeals you should refer to the documents provided to you by the HMO and/or Insurance Company.

QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO)

A Qualified Medical Child Support Order (QMCSO) may require the Plan to pay Plan benefits on account of eligible expenses incurred by Dependent Child(ren) covered by the Plan either to the provider who rendered the services or to the custodial parent of the Dependent Child(ren). If coverage of the Dependent Child(ren) is actually provided by the Plan, and if the Plan Administrator or its designee determines that it has received a QMCSO, it will pay Plan benefits on account of expenses incurred by Dependent Child(ren) to the extent otherwise covered by the Plan as required by that QMCSO. For additional information regarding QMCSOs, see the Eligibility chapter of this document.

WHEN YOU MUST REPAY PLAN BENEFITS

If it is found that the Plan benefits paid by the Plan are too much because:

1. some or all of the health care expenses were not payable by you or your covered Dependent; or
2. you or your covered Dependent received money to pay some or all of those health care expenses from a source other than the Plan; or
3. you or your covered Dependent achieve any recovery whatsoever, through a legal action or settlement in connection with any sickness or injury alleged to have been caused by a third party, regardless of whether or not some or all of the amount recovered was specifically for the health care expenses for which Plan benefits were paid (See also the Subrogation section of the COB chapter);or
4. the Plan erroneously paid benefits to which you were not entitled under the terms and provisions of the Plan; or
5. the Plan erroneously paid benefits because of false information entered on your enrollment form, claim form or required documentation;

then, the Plan will be entitled to

a. a refund from you or your Health Care Provider for the difference between the amount paid by the Plan for those expenses and the amount of Plan benefits that should have been paid by the Plan for those expenses based on the actual facts;

b. offset future benefits (that would otherwise be payable on behalf of you or your dependents) if necessary in order to recover such expenses; and/or

c. its attorney's fees, costs and expenses incurred in recovering monies that were wrongfully paid.

RECOVERY OF OVERPAYMENTS

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan. Another way that overpayments are recovered is by reducing future payments to the provider by the amount of the overpayment. These future payments may involve this Plan or other health plans that are administered by the Plan's third-party administrator -- Aetna. Under this process, Aetna reduces future payments to providers by the amount of the overpayments they received, and then credits the recovered amount to the plan that overpaid the provider. Payments to providers under this Plan are subject to this same process when Aetna recovers overpayments for other plans administered by Aetna.

This right does not affect any other right of recovery the Plan may have with respect to overpayments.

Time Limit for Initial Filing of Health Claims

All post-service claims must be submitted to the Plan within **ONE YEAR** from the date of service. No Plan benefits will be paid for any claim not submitted within this period.

Additional Information Needed: There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

WHEN YOU MUST GET PLAN APPROVAL IN ADVANCE OF OBTAINING HEALTH CARE

Some Plan benefits are payable without a financial penalty only if the Plan approves payment **before** you receive the services. These benefits are referred to as pre-service claims (also known as preauthorization or precertification). See the definition of pre-service claims in this chapter. You are not required to obtain approval in advance for emergency care or hospital admission for delivery of a baby.

KEY DEFINITIONS

Days: For the purpose of the claim and appeal procedures outlined in this chapter, "days" refers to calendar days, not business days.

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as:

- a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit or a beneficiary's eligibility to participate in this Plan; and
- a reduction in a benefit resulting from the application of any utilization review or failure to cover an item or service for which benefits are otherwise provided because it is determined to be experimental or investigational or not medically necessary or appropriate.

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this chapter) in accordance with the Plan's claims procedures, described in this chapter.

There are **four types of claims** covered by the procedures in this chapter: **Pre-service, Urgent, Concurrent, and Post-service**, described later in this chapter. The type of claim is determined as of the time the claim or review of denial of the claim is being processed.

A claim must include the following elements to trigger the Plan's claims processing procedures:

a. be **written or electronically** submitted (oral communication is acceptable only for urgent care claims),
b. be **received by the Appropriate Claims Administrator** as that term is defined in this chapter;
c. **name a specific individual**,
d. **name a specific medical condition or symptom**,
e. **name a specific treatment, service or product** for which approval or payment is requested, and
f. **made in accordance with the Plan's benefit claims filing procedures** described in this chapter.

A claim is NOT:

a. a request made by **someone other than** the individual or his/her authorized representative;
b. a request made by a **person who will not identify him/herself** (anonymous);
c. a **casual inquiry about benefits** such as verification of whether a service/item is a covered benefit or the estimated allowed cost for a service;
d. a request for **prior approval of Plan benefits where prior approval is not required** by the Plan;
e. an **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as an adverse benefit determination and the individual will be notified of the decision and allowed to file an appeal;
f. a **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim;
g. a **submission of a prescription** with a subsequent adverse benefit determination at the point of sale at a retail pharmacy or from a mail order service.
h. a request for an eye exam, lenses, frames or contact lenses with a subsequent adverse benefit determination at the point of sale from the Plan's contracted in-network PPO vision providers.

Appropriate Claims Administrator: means the companies and types of claims outlined in the chart below. (See the Quick Reference Chart in the front of this document for the name and address of these Appropriate Claims Administrators).

Appropriate Claims Administrator	Types of Claims Processed
Administration Office/Claims Administrator	• Medical post-service claims • COBRA post-service claims
Utilization Management Company	• Urgent, Concurrent and Preservice claims
Behavioral Health/EAP Program	• Preservice claims for EAP visits • Behavioral Health pre-service and urgent care claims (also called precertification review) as noted in Utilization Management chapter
Prescription Drug Program	• Pre-service drugs as described under the Drugs row of the Schedule of Medical Benefits
Dental Plan Administrator	• Post-service dental claims
Vision Plan Administrator	• Post-service vision claims

Pre-Service Claim: A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care. The services that require precertification (also called prior authorization) are listed in the Utilization Management chapter and the Drug row of the Schedule of Medical Benefits in this document.

The Plan Administrator may determine, in its sole discretion, to pay benefits for the services needing precertification (that were obtained without prior approval) if you were unable to obtain prior approval because circumstances existed that made obtaining such prior approval impossible, or application of the pre-service (precertification) procedure could have seriously jeopardized the patient's life or health.

Urgent Care Claim: An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for precertification:

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

The services that require precertification (also called prior authorization) are listed in the Utilization Management chapter and the Drug row of the Schedule of Medical Benefits in this document.

Concurrent Care Claim: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short. The services that will receive concurrent care review are listed in the Utilization Management chapter in this document.

Post-Service Claim: A post-service claim is a claim for benefits under the Plan that is not a pre-service claim. Post-service claims are claims that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim and an electronic bill, submitted for payment after services have been provided, are examples of post-service claims.

Health Care Professional: Means a Physician or other Health Care Professional licensed, accredited or certified to perform specified health services consistent with State law.

Tolled: Means stopped or suspended, particularly as it refers to time periods during the claims process.

Appeal Committee of the Board of Trustees: Appeals are decided by the Board of Trustees or the Appeal Committee which is a subset of the Board of Trustees comprised of one employer and one labor organization trustee.

REVIEW OF ISSUES THAT ARE NOT A CLAIM AS DEFINED IN THIS CHAPTER

A Plan participant may request review of an issue (that is not a claim as defined in this chapter) by writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. The request will be reviewed and the participant will be advised of the decision within the timeframes applicable to post-service claims.

AUTHORIZED REPRESENTATIVE

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an adverse benefit determination under this Plan (because of your death, disability or other reason acceptable to the Plan). An authorized representative under this Plan also includes a Health Care Professional.

The Plan requires a written statement from an individual that he/she has designated an authorized representative along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form (available from the Appropriate Claims Administrator or the Administration Office).

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g.* notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Appropriate Claims Administrator or the Administration Office.

In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), such Health Care Professional will be considered by this Plan to be your authorized representative bypassing the need for completion of the Plan's written authorized representative form.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

HOW TO FILE A POST-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

A claim for post-service benefits is a request for Plan benefits (that is not a preservice claim) made by you or your authorized representative, in accordance with the Plan's claims procedures, described in this chapter. See also the "Key Definitions" subheading of this chapter for a definition of a "claim" and the information on what is and is not considered a claim.

1. Plan benefits for post-service claims are considered for payment on the receipt of a **written** (or electronic where appropriate) proof of claim, commonly called a bill. A completed claim usually contains the necessary proof of claim but sometimes additional information or records may be required.
2. Generally, Plan benefits for a Hospital or Health Care Facility will be paid directly to the facility. Plan benefits for surgery will usually be paid directly to the surgeon and anesthesiologist providing the services.
3. If health care services are provided through the Preferred Provider Organization (PPO), the PPO Health Care Provider will usually submit the written proof of claim directly to the Appropriate Claims Administrator.
4. If you pay for non-PPO health care services at the time services are provided, you may later submit the bill to the Appropriate Claims Administrator. At the time you submit your claim you must furnish evidence acceptable to the Appropriate Claims Administrator that you or your covered dependent paid some or all of those charges. Plan benefits will be paid to you up to the amount allowed by the Plan for those eligible expenses. The Appropriate Claims Administrator will not accept a balance due statement, cash register receipts, photocopy, canceled checks or credit card receipts as proof of claim.
5. **Claim Forms:** Occasionally a health care provider will send a claim directly to you. In this case you should contact the Appropriate Claims Administrator (defined in this chapter) to find out if they require you to complete a claim form. If a claim form is required it may be obtained from the Appropriate Claims Administrator whose name and address are listed on the Quick Reference Chart in the front of this document.
    - Complete the employee part of the claim form in full. Answer every question, even if the answer is "none" or "not applicable (N/A)."
    - The instructions on the claim form will tell you what documents or medical information are necessary to support the claim. Your Physician or Health Care Practitioner or Dentist can complete the Health Care Provider part of the claim form, or you can attach the bill for professional services if it contains **all** of the following information:
        - A description of the services or supplies provided.
        - Details of the charges for those services or supplies, including CPT/CDT codes.
        - Diagnosis including ICD codes.
        - Date(s) the services or supplies were provided.
        - Patient's name, social security or ID number, address and date of birth.
        - Provider's name, address, phone number, professional degree or license, and federal tax identification number.
    - Please review your bills to be sure they are appropriate and correct. **Report any discrepancies in billing to the Appropriate Claims Administrator.** This can reduce costs to you and the Plan.
    - Complete a **separate claim form** for each person for whom Plan benefits are being requested.

- If another plan is the primary payer, send a copy of the other plan's Explanation of Benefits (EOB) along with the claim you submit to this Plan.
- Mail the claim form and a copy of the provider's actual claim to the Appropriate Claims Administrator.

6. In all instances, when deductibles, coinsurance or copayments apply, you are responsible for paying your share of the charges.
7. The Appropriate Claims Administrator will review your post-service claim no later than 30 calendar days from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.
   - This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30 day period using a written Notice of Extension.
   - The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
   - (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.)
   - The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.
   - **Proof of Dependent Status:** When processing claims submitted on behalf of a Dependent, follow the guidelines for Proof of Dependent Status located in the Eligibility chapter of this document.
     - When processing claims submitted on behalf of a **newborn Dependent** Child the Appropriate Claims Administrator must receive confirmation of the child's eligibility for coverage (*e.g.* copy of certified birth certificate for newborn).
     - When processing claims submitted on behalf of a **new spouse or domestic partner**, the Appropriate Claims Administrator must receive confirmation of the spouse's or domestic partner's eligibility (e.g. copy of Marriage Certificate) or Certification of Domestic Partnership.
   - When processing **claims related to an accident** the Appropriate Claims Administrator may need information about the details of the accident.
8. **If the post-service claim is approved,** you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits or EOB. The provider of service (or you when applicable) will be paid according to Plan benefits.
9. **If the post-service claim is denied** in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) on the Explanation of Benefits or EOB form. This notice of initial denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure along with time limits;
   - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed; and
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
10. **If you disagree with a denial of a post-service claim**, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A POST-SERVICE CLAIM

1. This Plan maintains a 1 level appeal process. Appeals must be in writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
     - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
     - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
2. Under this Plan's 1 level appeal process, the Plan will make an appeal determination according to the following timeframes:
   - **If an appeal is filed with the Plan <u>more than 30 days</u> before the next Board meeting**, the review will occur at the next Board meeting date.
   - **If an appeal is filed with the Plan <u>within 30 days</u> of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.
   - If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
   - After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.
3. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
4. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
5. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
6. This concludes the post-service appeal process under this Plan.

HOW TO FILE AN URGENT CARE CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves urgent care (as defined earlier in this chapter), you may file the claim or the Plan will honor a Health Care Professional as your authorized representative in accordance with the Plan's urgent care claims procedures described below.

1. Urgent care claims (as defined previously in this chapter) may be requested by you orally or by writing to the UM Company, Prescription Benefit Management firm (PBM) whose phone number, and mailing address are listed on the Quick Reference Chart in the front of this document.
2. In the case of an urgent care claim, if a Health Care Professional with knowledge of your medical condition determines that a claim involves urgent care (within the meaning of the definition of urgent care), the Health Care Professional will be considered by this Plan to be the authorized representative bypassing the need for completion of the Plan's written authorized representative form.
3. You will be notified of the Plan's benefit determination as soon as possible but **no later than 72 hours** after receipt of an urgent care claim by the UM Company or Prescription Drug Program. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.
4. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the UM Company or Prescription Drug Program, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.
5. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
6. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice. The notice of initial urgent care claim denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure along with time limits;
   - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request, and
   - you will be provided a description of the expedited appeal review process for urgent care claims.
7. **If you disagree with a denial of an urgent care claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF AN URGENT CARE CLAIM

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the UM Company or Prescription Drug Program, at their phone number or address listed on the Quick Reference Chart in the front of this document.
2. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the Plan will:
  - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
  - provide the identification of medical or vocational experts whose advice was obtained in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

3. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than 72 hours after receipt of the appeal.
4. The notice of appeal review of an urgent care claim will be provided orally with written (or electronic, as appropriate). You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
5. This concludes the urgent care claim appeal process under this Plan. This Plan does not offer a voluntary appeal process.

HOW TO FILE A CONCURRENT CLAIM FOR BENEFITS UNDER THIS PLAN

If your claim involves concurrent care (as that term is defined earlier in this chapter), you may file the claim by writing (orally for an expedited review) to the UM Company whose phone number and mailing address are listed on the Quick Reference Chart in the front of this document.

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.
2. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes noted under the Urgent care claim section of this chapter.
3. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Preservice or Post-service claim sections of this chapter.
4. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
5. **If the concurrent care claim is denied,** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. The notice of initial concurrent denial will:
   - give the specific reason(s) for the denial;
   - reference the specific Plan provision(s) on which the determination is based;
   - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
   - provide an explanation of the Plan's appeal procedure along with time limits;
   - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;

- if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.

6. **If you disagree with a denial of a concurrent claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A CONCURRENT CARE CLAIM

1. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the UM Company at their phone number or address listed on the Quick Reference Chart in the front of this document.
2. You will be provided with:
   - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
   - in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:
     - consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
     - provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
3. A determination will be made on the appeal (without the opportunity for extension) as soon as possible before the benefits is reduced or treatment is terminated.
4. The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
   - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
5. This concludes the concurrent claim appeal process under this Plan.

HOW TO FILE A PRE-SERVICE CLAIM FOR BENEFITS UNDER THIS PLAN

1. A claim for pre-service (as defined in this chapter) must be made by a claimant or the claimant's authorized representative (as described in this chapter) in accordance with this Plan's claims procedures outlined in this chapter.

2. A pre-service claim (claim that requires precertification) must be submitted (orally or in writing) in a timely fashion (as discussed in the Utilization Management chapter of this document) to the Appropriate Claims Administrator (as defined in this chapter).
3. The pre-service claim will be reviewed no later than 15 calendar days from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.
4. The 15 calendar day review period may be extended one time for up to 15 additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15-day period by using a written Notice of Extension.
5. (If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the earlier of the date on which you respond or 60 days has elapsed since the Notice was sent to you.)
6. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
7. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
8. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received, or the date displayed in the Notice of Extension on which a decision will make if no additional information is received.
9. **If the pre-service claim is approved** you will be notified orally and in writing (or electronic, as applicable).
10. **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable). This notice of initial denial will:
    - give the specific reason(s) for the denial;
    - reference the specific Plan provision(s) on which the determination is based;
    - describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;
    - provide an explanation of the Plan's appeal procedure along with time limits;
    - contain a statement that you have the right to bring civil action under ERISA section 502(a) after the appeal is completed; and
    - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
    - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request.
11. **If you disagree with a denial of a pre-service claim,** you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

APPEAL OF A DENIAL OF A PRE-SERVICE CLAIM

This Plan maintains one a level appeals process. Appeals must be in writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. You will be provided with:

- the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
- the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
- a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
- a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;
- in deciding an appeal of any adverse benefit determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not medically necessary or not appropriate, the appropriate named fiduciary will:

- consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the adverse benefit determination that is the subject of the appeal nor the subordinate of any such individual; and
- provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.

1. Under this Plan's one level appeal process, the Plan will make a determination on the appeal no later than 30 calendar days from receipt of the appeal. There is **no extension permitted** to the Plan in the appeal review process.
2. There is **no extension permitted** to the Plan in the first or second level of the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
3. If still dissatisfied with the initial appeal level determination you will have 180 calendar days under this Plan from receipt of the first level review determination to request a second level appeal review by writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document.
4. A second level determination will be made no later than 15 calendar days from receipt of the second level appeal.
5. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
6. If the claim was denied due to medical necessity, experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.
7. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
   - the specific reason(s) for the adverse appeal review decision;
   - reference the specific Plan provision(s) on which the determination is based;
   - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to the claim;
   - a statement that you have the right to bring civil action under ERISA section 502(a) following the appeal;
   - a statement of the voluntary Plan appeal procedures, if any;
   - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request;
   - if the denial was based on medical necessity, experimental treatment, or similar exclusion or limit, a statement will be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge to you, upon request; and
   - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
8. This concludes the pre-service appeal process under this Plan.

THE FOLLOWING CHART OUTLINES THE TIMEFRAMES FOR THE CLAIM FILING AND CLAIM APPEAL PROCESS:

Overview of Claims and Appeals Timeframes				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Plan must make **Initial Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	15 days	30 days
Extension permitted during initial benefit determination?	No[1]	No	15 days	15 days
Appeal Review must be submitted to the Plan within:	180 days	180 days	180 days	180 days
Plan must make **Appeal Claim Benefit Determination** as soon as possible but no later than:	72 hours	Before the benefit is reduced or treatment terminated.	30 days	According to the timeframes outlined in the chart below related to Board Meetings
Second Appeal Review must be submitted to the Plan within:	NA	NA	180 days	180 days

Overview of Claims and Appeals Timeframes				
	Urgent	**Concurrent**	**Pre-service**	**Post-service**
Extension permitted during appeal review?	No	No	No	No

No formal extension for urgent care claims but regulation does allow that if a claimant files insufficient information the claimant will be allowed up to 48 hours to provide the information.

Post-service Appeal Timeframes for Multiemployer Plan with Committee or Boards of Trustees that meet at least Quarterly		
Appeal filed **within 30 days** of the next Board meeting:	Board review occurs no later than the second meeting following receipt of the appeal.	If special circumstances require an extension of time, Board review can occur at the third meeting following receipt of the appeal.
Appeal filed **more than 30 days** before next Board meeting:	Board review occurs at the next Board meeting date.	If special circumstances require an extension of time, Board review can occur at the second meeting following receipt of the appeal.
Board's decision on the appeal to be provided to claimant as soon as possible after the Board decision but no later than 5 days after the Board's decision date.		

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits until after you have exhausted this Plan's Claims Appeal procedures or until the appropriate time frame 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 3 years after the end of the year in which health care services were provided.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

FACILITY OF PAYMENT

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

COORDINATION OF BENEFITS (COB)

HOW DUPLICATE COVERAGE OCCURS

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

- Another group health care plan (including but not limited to a plan which provides the Member with COBRA continuation coverage); or
- Medicare; or
- Other government program, such as Medicaid, Tricare, or a program of the U.S. Department of Veterans Affairs, motor vehicle including but not limited to no-fault, uninsured motorist or underinsured motorist coverage for medical expenses or loss of earnings that is required by law, or any coverage provided by a federal, state or local government or agency; or
- Duplicate recovery of health care expenses can also occur if there is any other coverage for your health care expenses including third party liability.

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

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

COVERAGE UNDER MORE THAN ONE GROUP HEALTH PLAN

When and How Coordination of Benefits (COB) Applies

1. For the purposes of this Coordination of Benefits chapter, the word "plan" refers to any group medical or dental policy, contract or plan, whether insured or self-insured, that provides benefits payable on account of medical or dental services incurred by the Participant or that provides health care services to the Participant. A "group plan" provides its benefits or services to employees, domestic partners, retirees or members of a group who are eligible for and have elected coverage plan (including but not limited to a plan that provides the Participant with COBRA continuation coverage).
2. Many families that have more than one family member working outside the home are covered by more than one medical or dental plan. If this is the case with your family, **you must let this Plan and its Claims Administrator or its insurer) know about <u>all</u> your coverages when you submit a claim.**
3. Coordination of Benefits (or COB, as it is usually called) operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. **In no event will the combined benefits of the primary and secondary plans exceed 100% of the health care expenses incurred.** Sometimes, the combined benefits that are paid will be less than the total expenses.

WHICH PLAN PAYS FIRST: ORDER OF BENEFIT DETERMINATION RULES

The Overriding Rules

A. Group plans determine the sequence in which they pay benefits, or which plan pays first, by applying a uniform order of benefit determination rules in a specific sequence. This Plan uses the order of benefit determination rules established by the National Association of Insurance Commissioners (NAIC) and which are commonly used by insured and self-insured plans. **Any group plan that does not use these same rules always pays its benefits first.**

B. When two group plans cover the same person, the following order of benefit determination rules establish which plan is the primary plan that pays first, and which is the secondary plan that pays second. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. These rules are:

Rule 1: Non-Dependent/Dependent

A. The plan that covers a person as an employee, retiree, member or subscriber (that is, other than as a dependent) pays first; and the plan that covers the same person as a dependent pays second.

B. There is one exception to this rule. If the person is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the person as a dependent; and primary to the plan covering the person as other than a dependent (that is, the plan covering the person as a retired employee); then the order of benefits is reversed, so that the plan covering the person as a dependent pays first; and the plan covering the person other than as a dependent (that is, as a retired employee) pays second.

Rule 2: Dependent Child Covered Under More Than One Plan

A. The plan that covers the parent whose Birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose Birthday falls later in the calendar year pays second, if:

   1. the parents are married;
   2. the parents are not separated (whether or not they ever have been married); or
   3. a court decree awards joint custody without specifying that one parent has the responsibility to provide health care coverage for the child.

B. If both parents have the same Birthday, the plan that has covered one of the parents for a longer period of time pays first; and the plan that has covered the other parent for the shorter period of time pays second.

C. The word "Birthday" refers only to the month and day in a calendar year; not the year in which the person was born.

D. If the specific terms of a court decree state that one parent is responsible for the child's health care expenses or health care coverage, and the plan of that parent has actual knowledge of the terms of that court decree, that plan pays first. If the parent with financial responsibility has no coverage for the child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any Plan Year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

E. If the parents are not married, or are separated (whether or not they ever were married), or are divorced, and there is no court decree allocating responsibility for the child's health care services or expenses, the order of benefit determination among the plans of the parents and their spouses (if any) is:

   1. The plan of the custodial parent pays first; and
   2. The plan of the spouse of the custodial parent pays second; and
   3. The plan of the non-custodial parent pays third; and
   4. The plan of the spouse of the non-custodial parent pays last.

Rule 3: Active/Laid-Off or Retired Employee

A. The plan that covers a person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee's dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee's dependent, pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 4: Continuation Coverage

A. If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

B. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

C. If a person is covered other than as a dependent (that is, as an employee, former employee, retiree, member or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 rather than by this rule.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the person for the longer period of time pays first; and the plan that covered the person for the shorter period of time pays second.

B. To determine how long a person was covered by a plan, two plans are treated as one if the person was eligible for coverage under the second plan within 24 hours after the first plan ended.

C. The start of a new plan does not include a change:

1. in the amount or scope of a plan's benefits;
2. in the entity that pays, provides or administers the plan; or
3. from one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a person is covered under a plan is measured from the date the person was first covered under that plan. If that date is not readily available, the date the person first became a member of the group will be used to determine the length of time that person was covered under the plan presently in force.

HOW MUCH THIS PLAN PAYS WHEN IT IS SECONDARY:

Secondary Liability of this Plan: When this Plan pays second, it will pay normal plan benefits **less** whatever payments were actually made by the plan (or plans) that paid first. It will reduce its benefits so that the total benefits paid or provided by all coordinating plans during a claim determination period for each claim as it is processed, is not more than 100% of total allowable expenses and in no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first. The claim determination period under this Plan is the one-year period measured from the date of service.

Credit Reserve: This Plan does administer a credit reserve (also called a benefit bank, credit balance, benefit reserve or credit savings) calculation in the coordination of benefits. When it does so, this Plan will calculate its savings by subtracting the amount that it pays as the secondary plan from the amount that it would have paid had it been the primary plan. These savings will be recorded as a credit reserve for the Participant for whom the claim is being determined and those savings in the credit reserve will be used by the secondary plan to pay any allowable expenses not otherwise paid from all previous claims incurred by that Participant during the current claim determination period. At the end of the claim determination period, all unused amounts in the credit reserve are canceled and a new credit reserve will be established with respect to claims incurred in the following claim determination period. Guidelines about this Plan's credit reserve include:

- The benefits reserve is used to pay claims incurred during any one claim determination period and the credit reserve cannot be carried over from one claim determination period into the next.
- The benefits reserve must be used throughout the entire claim determination period until the reserve amount is exhausted even though the other group health plan may have terminated during the claim determination period.
- The benefits reserve cannot be transferred and cannot be used to pay claims incurred by another family member.
- Credit reserve accumulations are used to pay for allowable expenses that the secondary plan does not cover, or to pay for allowable expenses that are covered only in part by both plans. The credit reserve is not used to pay an amount the primary plan did not pay because the allowable expense was reduced (such as for failure to obtain precertification).
- The credit reserve is not used to provide payments for benefits that have reached a plan limitation, are excluded by the Plan, or are subject to a pre-existing condition limitation.

"Allowable Expense" means a health care service or expense, including deductibles, coinsurance or copayments, which is covered in full or in part by any of the plans covering the person, except as provided below or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an allowable expense. The following are examples of expenses or services that are not allowable expenses:

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is medically necessary.
- If the coordinating plans determine benefits on the basis of Usual and Customary Charges, any amount in excess of the highest Usual and Customary Charge is not an allowable expense.
- If the coordinating plans provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an allowable expense.
- If one coordinating plan determines benefits on the basis of Usual and Customary Charges and the other coordinating plan provides Benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the allowable expense for all plans.
- When benefits are reduced by a primary plan because a Participant did not comply with the primary plan's provisions, such as the provisions related to Utilization Management in this Plan and similar provisions in other plans, the amount of those reductions will not be considered an allowable expense by this Plan when it pays second.

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

ADMINISTRATION OF COB

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

COORDINATION WITH MEDICARE

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

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

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

C. Coverage Under Medicare and This Plan When Totally Disabled: If an eligible individual under this Plan becomes Totally Disabled and entitled to Medicare because of that disability, the eligible employee will no longer be considered to remain actively employed. As a result, once entitled to Medicare because of that disability, Medicare pays first, and this Plan pays second.

D. Coverage Under Medicare and This Plan for End-Stage Renal Disease: If, while actively employed, an eligible individual under this Plan becomes entitled to Medicare because of end-stage renal disease (ESRD), this Plan pays first and Medicare pays second for 30 months starting the **earlier** of the month in which Medicare ESRD coverage begins; or the first month in which the individual receives a kidney transplant. Then, starting with the 31st month after the start of Medicare coverage, Medicare pays first, and this Plan pays second.

E. How Much This Plan Pays When It Is Secondary to Medicare

1. **When Covered by Medicare Parts A and B:** When an eligible individual under this Plan is covered by Medicare Parts A and B and this Plan is secondary to Medicare, this Plan pays the same benefits provided for active employees less any amounts paid by Medicare. Benefits payable by this Plan are based on the fees allowed by Medicare and not on the Usual and Customary Charges of the Health Care Provider.
2. **When Covered by Medicare Advantage (formerly called Medicare + Choice or Part C):** This Plan provides benefits that supplement the benefits received from Medicare Part A and B coverage. If an individual is covered by a Medicare Advantage program and obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will reimburse all applicable copayments and will pay the same benefits provided for active employees less any amounts paid by the Medicare Advantage program.

   However, if an eligible individual does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, precertification/preauthorization, case management or utilization of in-network provider requirements, this Plan will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the individual receives.
3. **When Not Covered by Medicare:** If an eligible individual under this Plan is **eligible for, but is not enrolled in Medicare**, this Plan pays the same benefits provided for active employees less the amounts that would have been paid by Medicare had the individual been covered by Medicare Parts A and B and not on the Usual and Customary Charges of the Health Care Provider.
4. **When a Person Enters into a Medicare Private Contract:** Under the law a Medicare participant is entitled to enter into a Medicare private contract with certain Health Care Practitioners under which he or she agrees that no claim will be submitted to or paid by Medicare for health care services and/or supplies furnished by that Health Care Practitioner. If a Medicare participant enters into such a contract this Plan will NOT pay any benefits for any health care services and/or supplies the Medicare participant receives pursuant to it.

COORDINATION WITH OTHER GOVERNMENT PROGRAMS

A. **Medicaid**: If an individual is covered by both this Plan and Medicaid, this Plan pays first, and Medicaid pays second.

B. **Tricare**: If a Covered Dependent is covered by both this Plan and Tricare, the program that provides health care services to dependents of active armed services personnel, this Plan, pays first and Tricare pays second. For an employee called to active duty for more than 30 days, and who is covered by both this Plan and Tricare, Tricare is primary, and this Plan is secondary.

C. **Veterans Affairs Facility Services**: If an eligible individual under this Plan receives services in a U.S. Department of Veterans Affairs Hospital or 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 Usual and Customary.

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.

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

WORKERS' COMPENSATION

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan may advance benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, the individual must execute a reimbursement agreement acceptable to the Plan Administrator or its designee.

THIRD PARTY LIABILITY

A. Advance on Account of Plan Benefits

The Plan does not cover expenses for services or supplies for which a third party is required to pay because of a negligent, wrongful or other act (See the exclusion regarding Expenses for Which a Third Party Is Responsible in the Exclusions chapter), but it will advance payment on account of Plan benefits (hereafter called an **"Advance"**), **subject to its right to be reimbursed to the full extent of any Advance payment from the Member and/or Dependent(s) if and when there is any recovery from any third party. The right of reimbursement will apply:**

1. even if the recovery is not characterized in a settlement or judgment as being paid on account of the medical or dental expenses for which the Advance was made; and
2. even if the recovery is not sufficient to make the ill or injured employee and/or dependent(s) whole pursuant to state law or otherwise (sometimes referred to as the "make-whole" rule); and
3. without any reduction for legal or other expenses incurred by the employee and/or dependent(s) in connection with the recovery against the third party or that third party's insurer pursuant to state law or otherwise (sometimes referred to as the "common fund" rule); and
4. regardless of the existence of any state law or common law rule that would bar recovery from a person or entity that caused the illness or injury, or from the insurer of that person or entity (sometimes referred to as the "collateral source" rule).

B. Reimbursement and/or Subrogation Agreement

The Member **and/or** any Dependent(s) on whose behalf the Advance is made, must sign and deliver a reimbursement and/or subrogation agreement (hereafter called the **"Agreement"**) in a form provided by or on behalf of the Plan. If the ill or injured Dependent(s) is a minor or incompetent to execute that Agreement, that person's parent (in the case of a minor dependent child) or spouse or legal representative (in the case of an incompetent adult) must execute that Agreement upon request by the Plan Administrator or its designee.

If the Agreement is not executed at the Plan Administrator's request, the Plan may refuse to make any Advance, but if, at its sole discretion, the Plan makes an Advance in the absence of an Agreement, **that Advance will not waive, compromise, diminish, release, or otherwise prejudice any of the Plan's rights**.

C. Cooperation with the Plan by All Participants

By accepting an Advance, regardless of whether or not an Agreement has been executed, the Member and/or Dependent(s) each agree to:

1. reimburse the Plan for all amounts paid or payable to the Member and/or Dependent(s) or that third party's insurer for the entire amount Advanced; and
2. do nothing that will waive, compromise, diminish, release, or otherwise prejudice the Plan's reimbursement and/or subrogation rights; and
3. notify and consult with the Plan Administrator or designee before starting any legal action or administrative proceeding against a third party based on any alleged negligent or wrongful act that may have caused or contributed to the injury or illness that resulted in the Advance, or entering into any settlement Agreement with that third party or third party's insurer based on those acts; and
4. inform the Plan Administrator or its designee of all material developments with respect to all claims, actions, or proceedings they have against the third party.

D. Subrogation

1. By accepting an Advance, the Member and/or Dependent(s) jointly agree that the Plan will be subrogated to the Member and/or dependent's right of recovery from a third party or that third party's insurer for the entire amount Advanced, regardless of any state or common law rule to the contrary, including without limitation, a so-called collateral source rule (that would have the effect of prohibiting the Plan from recovering any amount). This means that, in any legal action against a third party who may have wrongfully caused the injury or illness that resulted in the Advance, the Plan may be substituted in place of the Member and/or Dependent(s), but only to the extent of the amount of the Advance.
2. Under its subrogation rights, the Plan may, at its discretion:
   - start any legal action or administrative proceeding it deems necessary to protect its right to recover its Advances, and try or settle that action or proceeding in the name of and with the full cooperation of the Member and/or Dependent(s), but in doing so, the Plan will **not** represent, or provide legal representation for the Member and/or Dependent(s) with respect to their damages that exceed any Advance; or

- intervene in any claim, legal action, or administrative proceeding started by the Member and/or Dependent(s) against any third party or third party's insurer on account of any alleged negligent or wrongful action that may have caused or contributed to the injury or illness that resulted in the Advance.

E. Remedies Available to the Plan

If the Member and/or Dependent(s) does not reimburse the Plan as required by this provision, the Plan may, at its sole discretion:

1. apply any future Plan benefits that may become payable on behalf of the Member and/or Dependent(s) to the amount not reimbursed; or
2. obtain a judgment against the Member and/or Dependent(s) for the amount Advanced and not reimbursed, and garnish or attach the wages or earnings of the Member and/or Dependent(s).

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT INSURANCE

This chapter outlines the life and AD&D insurance coverage; however, where this chapter deviates from the certificate of coverage and summary of benefits produced by the insurance company, the insurance company documents will prevail. Contact the Administration Office for a copy of insurance coverage documents.

The Plan provides a group term life insurance plan through a Life Insurance Carrier whose name is listed on the Quick Reference Chart in the front of this document. The life insurance benefits are provided for members who meet the eligibility requirements for health coverage. No self-payment is required for this life insurance for active members and certain classes of retirees.

Beneficiary: You must complete a beneficiary form, naming your beneficiary and return it to the Local 19. You may change your beneficiary at any time by completing a new form.

OVERVIEW OF LIFE AND ACCIDENTAL DEATH AND DISMEMBERMENT INSURANCE		
Classification of Eligible Employees		**Amount of Life Insurance**
Class 1	All eligible active members (employed by a participating employer) who have worked at least 100 hours per month and are under age 70.	Life: $25,000 AD&D: $25,000
Class 2	All eligible active members, employed by a participating employer, who have worked at least 100 hours per month and are age 70 and over	$1,000
Class 3	All eligible retirees who have met the eligibility requirements for retired health coverage and have elected to self-pay their life insurance.	$12,000
Class 4	All eligible retired participants in good standing as of September 30, 1975 with the Hotel Employees, Restaurant Employees Local #19, other than Retired Bartenders and Central Coast participants in good standing as of October 1996, who are maintain said good standing with Local #19.	$1,500
Class 5	All eligible retired participants in good standing as of September 30, 1975 with the Hotel Employees, Restaurant Employees Local #19, other than Retired Bartenders, and Fresno participants in food standing as of October 1996, who also maintain said good standing with Local #19.	$1,000
Classification of Eligible Dependents – Class 1 Only		**Amount of Life Insurance**
Spouse, any age		$1,000
Child, live birth to age 21 or age 25 if full time student		$500

Total Disability, Totally Disabled or Disabled means that because of an injury or sickness you are completely and continuously unable to perform any work or engage in any occupation.

CONTINUANCE OF LIFE INSURANCE IF YOU BECOME TOTALLY DISABLED

If you become totally disabled, your life insurance will not end in accordance with the "When Your Insurance Ends" provision, but will be continued without payment of premium, provided:

a. The disability began while you were insured under this provision;
b. The disability began before you reached age 60; and
c. Proof of the disability is given to the Administration Office as described in the following paragraph.

You should send the Administration Office notice of your total disability no later than the ninth through the twelfth month of disability. The Administration Office will then send you the initial proof form for you and your physician to complete. Upon receipt and acceptance of initial proof by the Administration Office, insurance will continue for a period of one year.

Thereafter you and your physician must submit yearly proof that you are totally disabled. The proof must be submitted to the Life Insurance Carrier during the three-month period before each anniversary of receipt of initial proof. If proof is acceptable to the Life Insurance Carrier, insurance will be continued for further terms of one year. However, insurance will not be continued beyond the date you are no longer totally disabled.

If you die before proof of total disability is submitted to the Administration Office, benefits will still be payable provided:

a. Your death was within 12 months from the day insurance would have otherwise ended in accord with the "When Your Insurance Ends" provision; and

b. The Administration Office receives proof that total disability was uninterrupted from the date insurance would otherwise have ended until your death.

Your continued insurance is the amount in force on the day insurance would have otherwise ended. Continued insurance is subject to any **reductions** and **terminations** shown in the **Schedule of Life Insurance Benefits**.

In order to confirm that you are totally disabled, the Life Insurance Carrier has the right to have you examined by a physician of their choice. The Life Insurance Carrier will pay for these examinations. The Life Insurance Carrier may have you examined any time during the first two years of disability and one a year from then on.

When your total disability ends, you have 31 days to convert your coverage to an individual policy of life insurance; but you may not convert if you again become insured under the policy. Conversion may be made only in accordance with the conversion policy provision.

If a conversion policy has been issued to you, the Life Insurance Carrier will pay benefits under this continuance provision only if the conversion policy is returned without claim. The Life Insurance Carrier will refund all paid conversion premiums if your conversion policy is surrendered for this reason.

CONVERSION PRIVILEGE

If you are no longer eligible for group life insurance due to your ceasing to belong to an eligible insured class or if you terminate your employment, you may convert that benefit to any form of individual life insurance, except for term insurance. You may not apply for supplemental coverage.

You will not need a medical examination, but you must complete the application form and send it with the first premium payment to the Life Insurance Carrier (whose name and address are listed on the Quick Reference Chart in the front of this document) no later than 31 days after your group life insurance has terminated.

The face value of your new policy cannot be more than the amount you had under the group plan. The rate you pay will depend upon your age (at the nearest birthday to the date of issue of the individual policy) and your class of risk at the time of your conversion.

You may also convert if your life insurance benefits terminate because the policy terminates, or because life insurance benefits for your class terminate. In this case, however, you must have been covered under the group plan for at least five years. You may convert up to the amount of life insurance you have under this Plan, less any new amount of life insurance you have or for which you may become eligible under another group plan within 31 days of the termination, but the amount may not exceed $3,000.

If you should die within the 31-day period after your group life insurance has terminated, the Life Insurance Carrier will pay the group life insurance benefits to the last beneficiary you named, whether or not you applied for an individual life insurance policy.

DEPENDENT LIFE INSURANCE BENEFITS

If one of your insured dependents dies, the amount of insurance then in effect on the life of that dependent will be paid to you as the beneficiary. If you are not living, and benefits are payable because of the death of your spouse, payment will be made to the estate of your spouse. If you are not living, and benefits are payable because of the death of your child, payment will be made to the surviving parent, otherwise to the surviving brothers and sisters, or to the estate of the deceased child.

Domestic partners are not eligible for life insurance benefits.

DEPENDENT CONVERSION PRIVILEGE

If your insurance terminates, the insurance on your dependents will terminate. However, your dependents may convert their life insurance to individual life insurance on the same basis as explained for members under conversion privilege described earlier in this chapter.

EXTENDED INSURANCE

If a dependent dies within 31 days from the day dependents life insurance is terminated, benefits will still be paid. Upon receipt of proof within one year after death, the Administration Office will pay the amount for which the dependent was last insured. If a conversion policy has been issued to the deceased spouse, the Life Insurance Carrier will pay benefits under this Extended Insurance provision only if the conversion policy is returned without claim. The Life Insurance Carrier will refund all paid conversion premiums if the conversion policy is surrendered for this reason.

ACCIDENTAL DEATH AND DISMEMBERMENT (For Class 1 only)

Benefits: If, while insured under this provision, you are accidentally injured, and the injury is independent of sickness and all other causes, benefits will be paid, as shown in the table below, for any of the following losses:

SCHEDULE OF ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS	
LOSS	**BENEFIT**
Life	Principal Sum
Both Hands	Principal Sum
One hand and one foot, one hand and one eye, or one foot and one eye	Principal Sum
One hand, one foot or one eye	One-half Principal Sum
Thumb and index finger of same hand	One-fourth Principal Sum

The **Principal Sum** is shown in the **Schedule**. If the injury causes more than one loss, only the largest Benefit is payable.

- **Loss of a hand** means the severance at or above the wrist joint.
- **Loss of a foot** means the severance at or above the ankle joint.
- **Loss of thumb and index finger** means the severance of two or more phalanges of both the thumb and the index finger.
- **Loss of an eye** means the total loss of sight in that eye.

PAYMENT FOR LOSS OF LIFE

Beneficiary: Benefits payable under this provision because of your death will be paid to the beneficiary you name. If you do not name a beneficiary or if no beneficiary survives you, benefits will be paid:

a. To your surviving spouse; if none, then
b. To your surviving natural and/or adopted children; if none, then
c. To your surviving parent(s); if none, then
d. To your estate.

Benefits will be paid equally among surviving children or surviving parents.

MODE OF PAYMENT

Death benefits will be paid as follows:

a. In a lump sum; or
b. In other than a lump sum if:
    1. Another mode of payment is requested as described below; and
    2. The Administration Office agrees to it in writing.

BENEFICIARY OR MODE OF PAYMENT CHANGE

The beneficiary and mode of payment may be changed unless this right has been given up. To make a change, written request should be sent to the Administration Office. When recorded and acknowledged, the change will take effect as of the date the request is signed. However, the change will not apply to any payments or other action taken before the request was acknowledged.

PAYMENT FOR OTHER THAN LOSS OF LIFE

Benefits payable under this provision for any loss other than life will be paid to you in a lump sum.

EXCEPTIONS

Benefits will not be paid for any loss which:

a. Is not permanent;
b. Occurs more than 90 days after the injury;
c. Is caused by carbon monoxide poisoning;
d. Is caused by allergic reactions;
e. Results from injuries you receive in any aircraft other than while riding as a passenger in a commercial aircraft on a regularly scheduled flight;
f. Results from injuries you receive while riding in any aircraft engaged in:
    1. Racing;
    2. Endurance tests; or
    3. Acrobatic or stunt flying; or
g. Is excluded under the General Exclusions and Limitations.

HOUSING BENEFIT

The Trustees of the South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund have established the Housing Benefit Fund to assist membership with various housing affordability issues. **This benefit is only available to members of employers contributing to the Housing Benefit Fund.**

BENEFITS

The Housing Benefit Fund is intended to provide the following benefits:

- To forestall or help forestall foreclosure; or
- To forestall or help forestall eviction; or
- To contribute towards closing costs in the purchase of a first home; or
- To contribute towards a security deposit when renting a home.

On an annual basis, the Trustees determine a specific set uniform amount designated as the "annual benefit amount" and each applicant who applies for a benefit (while there are assets available) shall receive that specific "annual benefit amount."

HOW TO FILE A CLAIM

The applicants shall fill in a form provided by the Trust to make application for a benefit, and the form shall include a list of all documents necessary to prove that the benefit shall be used for one of the four designated purposes.

QUALIFICATIONS

The Trustees shall establish uniform qualifications for receipt of a benefit, which would be shown by the documents required to be shown. For example, a notice of eviction might be one of the documents required to forestall an eviction, to be provided with various other documents, such as proof of earnings, outstanding debts, etc.

PAYMENT

Once approved for payment, the benefit can be paid to the participant or directly to a third party, at the sole discretion of the Trustees.

PLAN PROVISIONS

The Health and Welfare Fund shall receive and separately account for contributions for certain housing benefits as outlined in this Benefit Plan and Summary Plan Description, to be incorporated in whole as though set forth in the Plan and SPD of the Health Fund

The Trustees shall collect contributions for at least one year before providing any benefits, in order to accumulate adequate assets to provide uniform benefits to certain applicants, on a first come/first served basis each year.

At the end of the first year, and at the end of each subsequent year, the Trustees shall receive a full accounting of all assets available for benefits at the end of each Plan Year and shall determine a specific set uniform amount designated as the "annual benefit amount" and each applicant who applies for a benefit while there are assets available shall receive that specific "annual benefit amount." For example, the Trustees might decide to wait until the Housing benefit contributions have reached $200,000. At that point, the Trustees might choose to make the uniform benefit amount $2500, so that 40 awards could be made on a first come/first serve basis to those who qualified. The Trustees could do this on an annual basis, or they might, once reserves are sufficient, choose to allocate further amounts on a semi-annual or quarterly basis to those who proved eligibility.

The Trustees shall have final and binding authority to interpret and apply the terms of the Trust Agreement, as well as the Benefit Plan and SPD terms.

In the event of any dispute between a participant and the Trustees, the sole issue shall be whether the Trustees have abused their discretion and shall be submitted solely to a mutually selected neutral third party for final and binding arbitration.

CLAIM FILING AND APPEAL INFORMATION

The Plan takes steps to assure that **Plan provisions are applied consistently** with respect to you and other similarly situated Plan participants. The following claims procedures will **afford you a full, fair and fast review of the claim to which it applies**. It is the intent of the Plan that the rules for claim processing and appeals be in compliance with 29 CFR 2560.503, as amended.

The following also addresses the process the Plan (described in this document) undertakes on **certain appealed claims.**

RECOVERY OF OVERPAYMENTS

If a benefit payment is made by the Plan, to you or on your behalf, which exceeds the benefit amount that you are entitled to receive, the Plan has the right to require the return of the overpayment. The Plan has the right to reduce by the amount of the overpayment, any future benefit payment made to or on behalf of a Participant in the Plan.

Additional Information Needed: There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time is allowed for you to submit this additional information. The Plan is not legally required to consider information submitted after these stated time frames.

KEY DEFINITIONS

Days: For the purpose of the claim and appeal procedures outlined in this chapter, "days" refers to calendar days, not business days.

Adverse Benefit Determination: For the purpose of the initial and appeal claims processes, an adverse benefit determination is defined as a denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit or a beneficiary's eligibility to participate in this Plan; and

Claim: For purposes of benefits covered by these procedures, a claim is a request for a Plan benefit made by an individual (commonly called the "claimant" but hereafter referred to as "you") or that individual's authorized representative (as defined later in this chapter) in accordance with the Plan's claims procedures, described in this chapter.

Appeal Committee of the Board of Trustees: Appeals are decided by the Board of Trustees or the Appeal Committee which is a subset of the Board of Trustees comprised of one employer and one labor organization trustee.

REVIEW OF ISSUES THAT ARE NOT A CLAIM AS DEFINED IN THIS CHAPTER

A Plan participant may request review of an issue (that is not a claim as defined in this chapter) by writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. The request will be reviewed and the participant will be advised of the decision within the timeframes applicable to post-service claims.

AUTHORIZED REPRESENTATIVE

This Plan recognizes an authorized representative as any person at least 18 years old whom you have designated in writing as the person who can act on your behalf to file a claim and appeal an adverse benefit determination under this Plan (because of your death, disability or other reason acceptable to the Plan).

The Plan requires a written statement from an individual that he/she has designated an authorized representative along with the representative's name, address and phone number. To designate an authorized representative, you must submit a completed authorized representative form (available from the Appropriate Claims Administrator or the Administration Office).

Where an individual is unable to provide a written statement, the Plan will require written proof that the proposed authorized representative has the power of attorney for health care purposes (*e.g*. notarized power of attorney for health care purposes, court order of guardianship/conservatorship or is the individual's legal spouse, parent, grandparent or child over the age of 18).

Once the Plan receives an authorized representative form all future claims and appeals-related correspondence will be routed to the authorized representative and not the individual. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. A participant may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Appropriate Claims Administrator or the Administration Office.

The Plan reserves the right to withhold information from a person who claims to be your authorized representative if there is suspicion about the qualifications of that individual.

APPEAL OF A DENIAL OF A CLAIM

1. This Plan maintains a 1 level appeal process. Appeals must be in writing to the Board of Trustees whose address is listed on the Quick Reference Chart in the front of this document. You will be provided with:
    - the opportunity, upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
    - the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
    - a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
    - a review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the adverse benefit determination that is the subject of the appeal, nor the subordinate of such individual;

2. Under this Plan's 1 level appeal process, the Plan will make an appeal determination according to the following timeframes:
    - **If an appeal is filed with the Plan more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date.
    - **If an appeal is filed with the Plan within 30 days of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.
    - If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.
    - After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than 5 calendar days after the benefit determination is made.
3. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person at a higher level of management than the person who originally denied the claim.
4. You will receive a notice of the appeal determination. If that determination is adverse, it will include:
    - the specific reason(s) for the adverse appeal review decision;
    - reference the specific Plan provision(s) on which the determination is based;
    - a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
    - a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;
    - a statement of the voluntary Plan appeal procedures, if any;
    - if the denial was based on an internal rule, guideline, protocol or similar criterion, a statement will be provided that such rule, guideline, protocol or criteria that was relied upon will be provided free of charge to you, upon request; and
    - the statement that "You and your Plan may have other voluntary dispute resolution options such as mediation. One way to find out what may be available is to contact your local U. S. Department of Labor Office and your State insurance regulatory agency."
5. This concludes the appeal process under this Plan.

LIMITATION ON WHEN A LAWSUIT MAY BE STARTED

You may not start a lawsuit to obtain benefits until after you have exhausted this Plan's Claims Appeal procedures or until the appropriate time frame 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 3 years after the end of the year in which health care services were provided.

DISCRETIONARY AUTHORITY OF PLAN ADMINISTRATOR AND DESIGNEES

In carrying out their respective responsibilities under the Plan, the Plan Administrator or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

CHILD CARE PROGRAM

ELIGIBILITY

You are eligible for the Child Care Program if you meet the Eligibility, Self-Pay and Dependent Contribution Rules of the Health and Welfare Plan. To be eligible, the benefit must make it possible for a Participant or his or her Spouse to work, or for a Spouse to attend school full time.

BENEFITS

The Child Care Program pays a monthly benefit of $49.00 for each family. Expenses must be incurred from the following to be eligible for the $49.00 Monthly Benefit:

- Licensed/Certified Day Care Providers.
- Licensed Day Care Centers for pre-school children.
- Licensed Day Camps and After School Programs.

INELIGIBLE EXPENSES

The following expenses are not considered eligible expenses under the Child Care Program:

- Child Care for a non-licensed Nursery School or Day Care Center.
- Child Care for a child who does not live with the Participant.
- Expense payments to the Participant's dependents, Spouse or other relatives.
- Babysitting.
- Overnight camps or other activities.
- Other expenses as may be determined by the Trustees.

To receive benefits, a canceled check or itemized receipt for expenses is required and must be submitted with the completed Child Care Claim Form to the Administration Office within 60 (sixty) days of the expense. You and the licensed agency must sign the claim form in order to be reimbursed by the Program. Claim forms can be obtained from the Administration Office or the Local Union Office.

GENERAL PROVISIONS AND INFORMATION REQUIRED BY ERISA

NAME OF THE PLAN

South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund

NAME AND ADDRESS OF PLAN SPONSOR MAINTAINING THE PLAN

South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund
P.O. Box 34203
Seattle WA 98124-1203

EMPLOYER IDENTIFICATION NUMBER

94-6080365

TYPE OF PLAN

This is a Health and Welfare Plan providing eligible employees, retirees and dependents (including domestic partners) with the following benefits: medical (including prescription drug), dental and vision expense benefits. Life and Accidental Death and Dismemberment (AD&D) benefits are available for certain plan participants. Housing and Child Care benefits are also available for certain plan participants.

PLAN NUMBER

501

TYPE OF ADMINISTRATION

The South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund is liable for eligible expenses of the self-funded medical plan (including prescription drugs), and claims for these Plan benefits are administered by independent claims administrators as listed on the Quick Reference Chart in the front of this document.

Independent insurance companies (whose name and address are listed on the Quick Reference Chart in the front of this document) administer the fully insured benefits of this Plan (including the Dental Plans, Vision Plan, Life Insurance and AD&D benefits) and provide payment of claims associated with these benefits.

PLAN ADMINISTRATOR

The official Plan Administrator is the Board of Trustees. The Board of Trustee is responsible for the operation of the Trust Fund and is comprised of an equal number of Union-appointed Trustees and Employer-appointed Trustees.

The Board of Trustees of the South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund
P.O. Box 34203
Seattle WA 98124-1203

CLAIMS REVIEW FIDUCIARY (CLAIMS ADMINISTRATORS)

Administration services are provided to the Plan under contracts with third party Claims Administrators whose names and addresses are listed on the Quick Reference Chart in the front of this document.

AGENT FOR SERVICE OF LEGAL PROCESS

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

Mr. William Sokol and Mr. Alan G. Crowley
Weinberg, Roger & Rosenfeld
1001 Marina Village Parkway, Suite 200
Alameda, CA 94501

Legal process may also be served on the plan administrator or trustees. For disputes arising under those portions of the Plan insured by an insurance company, service of legal process may be made upon the insurer at the address listed on the Quick Reference Chart in the front of this document, or upon the supervisory official of the State Insurance Department.

PLAN TRUSTEES

The Trustees of the Plan are:

Union Trustees	Management Trustees
Enrique Fernandez, Chairman HERE Local 19 2302 Zanker Road, 2nd Floor San Jose, CA 95131 Phone: (408) 321-9019	John Southwell, Secretary San Jose Marriott 301 S Market Street San Jose, CA 95113 Phone: (408) 278-4420
Rosa Rodriguez HERE Local 19 2302 Zanker Road, 2nd Floor San Jose, CA 95131 Phone: (408) 321-9019	Jimmy Sarfraz San Jose Hilton 300 Almaden Boulevard San Jose, CA 95110 (408) 947-4455
Sarah Julian HERE Local 19 2302 Zanker Road, 2nd Floor San Jose, CA 95131 Phone: (408) 321-9019	Jackie Dacanay Fairmont San Jose 170 S Market St. San Jose, CA 95113 (408) 998-3933
Raquel Alvarez HERE Local 19 2302 Zanker Road, 2nd Floor San Jose, CA 95131 Phone: (408) 321-9019	Jim Beard Beard Affiliates, LLC 5 Thomas Mellon Cir, Ste 111 San Francisco, CA 94134 (415) 710-4794

PLAN'S REQUIREMENTS FOR ELIGIBILITY AND BENEFITS

The Plan's requirements with respect to eligibility as well as circumstance that may result in disqualification, ineligibility or denial or loss of benefits are described in the Eligibility chapter in this document. The benefits provided by the Plan are described in the remaining chapters of this SPD/Plan Document.

COLLECTIVE BARGAINING AGREEMENTS

This Plan is maintained pursuant to one or more collective bargaining agreements. A copy of such agreements may be obtained by Members and Beneficiaries upon written request to the Board of Trustees and is available to for examination by Members and Beneficiaries.

SOURCES OF CONTRIBUTION TO THE PLAN

Contributions to the Plan are made by employers through collective bargaining agreements and in certain circumstances, self-payment.

PLAN YEAR

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

CONTROL DOCUMENT

The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail.

STATEMENT OF ERISA RIGHTS

As a participant in the **South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund**, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to:

Receive Information About Your Plan and Benefits:

1. Examine, without charge, at the Plan Administrator's office (7525 SE 24th Street, Suite 200 Mercer Island WA 98040 and at the local union office) all documents governing the Plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

1. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the COBRA chapter. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.
2. Reduction or elimination of exclusionary periods of coverage for Pre-Existing Conditions under your group health plan if you have creditable coverage from another plan. You may request a Certificate of Creditable Coverage, free of charge, from your group health plan or health insurer when you lose coverage under the plan, when you become entitled to elect COBRA Continuation Coverage, when your COBRA Continuation Coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

1. If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.
2. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.
3. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court. See the Plan's Claims Filing and Appeal information on the requirement to appeal a denied claim before filing a lawsuit.
4. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.
5. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

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

PLAN AMENDMENTS OR TERMINATION OF PLAN

THE TRUSTEES RESERVE THE RIGHT TO AMEND OR TERMINATE THIS PLAN, OR ANY PART OF IT AT ANY TIME. AMENDMENTS MAY BE MADE IN WRITING BY THE BOARD OF TRUSTEES AND BECOME EFFECTIVE ON THE TRUSTEES' WRITTEN APPROVAL OR ON SUCH OTHER DATE AS MAY BE SPECIFIED IN THE DOCUMENT AMENDING THE PLAN. THE PLAN OR ANY COVERAGE UNDER IT MAY BE TERMINATED BY THE BOARD OF TRUSTEES AND NEW COVERAGES MAY BE ADDED BY BOARD OF TRUSTEES. IF THE PLAN OR TRUST FUND IS TERMINATED, THE REMAINING ASSETS WILL BE USED TO CONTINUE TO PROVIDE BENEFITS UNTIL THERE ARE NO ASSETS REMAINING OR WILL BE USED IN A MANNER CONSISTENT WITH THE PURPOSES OF THE PLAN. IN NO EVENT WILL TERMINATION OF THE TRUST FUND OR PLAN RESULT IN A REVERSION OF ASSETS TO ANY EMPLOYER.NO LIABILITY FOR PRACTICE OF MEDICINE

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

RIGHT OF PLAN TO REQUIRE A PHYSICAL EXAMINATION

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

INFORMATION YOU OR YOUR DEPENDENTS MUST FURNISH TO THE PLAN (Very Important Information)

In addition to information you must furnish in support of any claim for Plan benefits under this Plan, you or your covered Dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan. **If you fail to do so, you or your covered Dependents may lose the right to obtain COBRA Continuation Coverage or to continue coverage of a Dependent Child who has a physical or mental Handicap.**

Submit such information in writing to the Administration Office. The information needed and timeframes for submitting such information are outlined below. See also the COBRA chapter for special timeframes applicable to those benefits:

Type of Information Needed	Date Information is to be Submitted to the Plan
• Change of name or address or the existence of other health care coverage for any Participant.	As soon as possible but not later than 60 days after the change or addition of other coverage.
• Marriage, divorce, legal separation, addition of a new Dependent, death of any Participant.	Within 30 days
• Dependent (spouse or child) becomes handicapped/disabled or is no longer handicapped/disabled.	Within 30 days of the date the person becomes disabled or is no longer disabled.
• Child ceases to be a Dependent as defined by this Plan (*e.g.* over the limiting age of the Plan, etc.)	Within 60 days of the date the child is no longer considered a Dependent.
• Employee receives a determination of disability from the Social Security Administration (SSA) or is no longer disabled according to SSA. • Medicare enrollment or disenrollment.	See the COBRA chapter for timeframe.

HEADINGS, FONT AND STYLE DO NOT MODIFY PLAN PROVISIONS

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

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

Effective April 14, 2003, a federal law, the **Health Insurance Portability and Accountability Act of 1996 (HIPAA),** requires that health plans like the South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund (hereafter referred to as the "Plan"), maintain the privacy of your personally identifiable health information (called **Protected Health Information or PHI**).

- The term **"Protected Health Information" (PHI)** includes all information related to your past, present or future health condition(s) that individually identifies you or could reasonably be used to identify you and is transferred to another entity or maintained by the Plan in oral, written, electronic or any other form.
- **PHI does not include** health information contained in employment records held by your employer in its role as an employer, including but not limited to health information on disability, work-related illness/injury, sick leave, Family and Medical leave (FMLA), and life insurance.

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was distributed to you upon enrollment in the Plan and is available from the Administration Office or on the website: www.southbayheretrust.com. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

The Plan, and the Plan Sponsor (the Board of Trustees of the South Bay Hotel Employees & Restaurant Employees Health & Welfare Trust Fund), will not use or further disclose information that is protected by HIPAA ("protected health information or PHI") except as necessary for treatment, payment, health care operations and Plan administration, or as permitted or required by law. **In particular, the Plan will not, without your written authorization, use or disclose protected health information for employment-related actions and decisions or in connection with any other benefit or employee benefit plan of the Plan Sponsor**. The Plan may disclose PHI to the Plan Sponsor for the purpose of reviewing a benefit claim or for other reasons related to the administration of the Plan.

A. **The Plan's Use and Disclosure of PHI:** The Plan will use protected health information (PHI), without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.
   - **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers.
   - **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
     a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copayments as determined for an individual's claim), and establishing employee contributions for coverage;
     b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes), coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;
     c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including precertification, concurrent review and/or retrospective review.
   - **Health Care Operations** includes, but is not limited to:
     a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies and quality assessment,
     b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,
     c. Underwriting, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities,
     d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs,
     e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.
     f. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

B. **When an Authorization Form is Needed:** Generally the Plan will require that you sign a valid authorization form (available from the Administration Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations. The Plan's Notice

of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:
   1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,
   2. Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA privacy rules.
   3. Not use or disclose the information for employment-related actions and decisions,
   4. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
   5. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
   6. Make PHI available to the individual in accordance with the access requirements of HIPAA,
   7. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
   8. Make available the information required to provide an accounting of PHI disclosures,
   9. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Dept. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
   10. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

D. **In order to ensure that adequate separation between the Plan and the Plan Sponsor is maintained** in accordance with HIPAA, only the following employees or classes of employees may be given access to use and disclose PHI: Business Associates under contract to the Plan including but not limited to the medical/dental claims administration office, preferred provider organization network, utilization management company, and COBRA administrator.

E. The persons described in section D above may only have access to and use and disclose PHI for Plan administration functions that the Plan Sponsor performs for the Plan. If these persons do not comply with this obligation, the Plan Sponsor has designed a mechanism for resolution of noncompliance. **Issues of noncompliance** (including disciplinary sanctions as appropriate) will be investigated and managed by the Plan's Privacy Officer whose address and phone number are listed on the Quick Reference Chart in the front of this document.

F. Effective April 21, 2005 in compliance with **HIPAA Security** regulations, the Plan Sponsor will:
   1. 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,
   2. Ensure that the adequate separation discussed in D above, specific to electronic PHI, is supported by reasonable and appropriate security measures,
   3. 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
   4. Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the medical Plans in which you may enroll may not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following a normal delivery or less than 96 hours following a cesarean section delivery. In accord with Federal Law, those Plans do not require that a provider obtain pre-authorization under those Plans for either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than the applicable time period.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Your Plan covers medical and surgical benefits for mastectomies. Effective July 1, 1999, this coverage includes:

1. Reconstruction of the breast on which the mastectomy was performed;

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; or
3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions.

GENETIC INFORMATION NONDISCRIMINATION ACT

The Genetic Information Nondiscrimination Act of 2008 (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. To comply with this law, the Plan asks that you not provide any genetic information when responding to requests for medical information. "Genetic information" as defined by GINA, includes an individual's family medical history, the results of an individual's or family member's genetic tests, the fact that an individual or an individual's family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual's family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans (such as this Plan) and health insurers (such as Kaiser) that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations) and treatment limitations (e.g., number of visits or days of coverage) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits. Pursuant to the Final MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants, or contracting providers, upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits will also be provided upon request.

It is the intention of the Board of Trustees and the contracted insurers (Kaiser Permanente) that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at www.dol.gov/ebsa/mentalhealthparity/.

GRANDFATHERED HEALTH PLAN

This plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the law was enacted.

Being a grandfathered plan means that this Plan does not include certain consumer protections of the Affordable Care Act that may apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, this Plan must comply with other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Administration Office at 800-544-5085, option 0. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan. Certain definitions pertaining to claims administration are found in the Claim Filing and Appeals Information chapter of this document.

Accident: A sudden and unforeseen event as a result of an external or extrinsic source, that is not work-related, and that occurred while the Plan Participant was covered under the Plan. See also the term Injury to Teeth.

Active Course of Orthodontia Treatment (Dental): The period beginning when the first orthodontic appliance is installed and ending when the last active appliance is removed.

Activities of Daily Living: Activities performed as part of a person's daily routine, such as getting in and out of bed, bathing, dressing, feeding or eating, use of the toilet, ambulating, and taking drugs or medicines that can be self-administered.

Acupuncture: A technique for treating disorders of the body by passing long thin needles through the skin. This technique is based on the belief that physical illness and disorders are caused by imbalances in the life force, called Qi, which flows through the body along meridians or channels, and that the needles stimulate the natural healing energy flow.

Administration Office: The person, firm and/or company designated by the Board of Trustees to handle the daily administrative duties of the Plan including payment of benefits provided by the Plan. The Administration Office is also known as the Claims Administrator under this Plan.

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

Allowable Expense: A health care service or expense, including deductibles, coinsurance or copayments, that is covered in full or in part by any of the plans covering a Plan Participant (see also the COB chapter of this document), except as otherwise provided by the terms of this Plan or where a statute applicable to this Plan requires a different definition. This means that an expense or service (or any portion of an expense or service) that is not covered by any of the plans is not an Allowable Expense.

Allowable Amount: Maximum amount on which payment is based for covered health care services. This might be called "eligible expense," "payment allowance" or "negotiated rate." If your provider charges more than the allowed amount, you may have to pay the difference. (See Balance Billing.)

Ambulance: A vehicle, helicopter, airplane or boat that is licensed or certified for emergency patient transportation by the jurisdiction in which it operates.

Ambulatory Surgical Facility/Center: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing surgical procedures and which fully meets one of the following two tests:

1. It is licensed as an Ambulatory Surgical Facility/Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
    - It is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
    - It requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
    - It provides at least one operating room and at least one post-anesthesia recovery room.
    - It is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
    - It has trained personnel and necessary equipment to handle emergency situations.
    - It has immediate access to a blood bank or blood supplies.
    - It provides the full-time services of one or more registered graduate nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
    - It maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history and laboratory tests and/or x-rays), an operative report and a discharge summary.

An Ambulatory Surgical Facility/Center that is part of a Hospital, as defined in this chapter, will be considered an Ambulatory Surgical Facility/Center for the purposes of this Plan.

Ancillary Services: Services provided by a Hospital or other Health Care Facility other than room and board, including but not limited to, use of the operating room, recovery room, intensive care unit, etc., and laboratory and x-ray services, drugs and medicines, and medical supplies provided during confinement.

Anesthesia: The condition produced by the administration of specific agents (anesthetics) to render the patient unconscious and without conscious pain response (e.g. general anesthesia), or to achieve the loss of conscious pain response and/or sensation in a specific location or area of the body (e.g. regional or local anesthesia). Anesthetics are commonly administered by injection or inhalation.

Appliance (Dental): A device to provide or restore function or provide a therapeutic (healing) effect. **Fixed Appliance:** A device that is cemented to the teeth or attached by adhesive materials. **Prosthetic Appliance:** A removable device that replaces a missing tooth or teeth.

Appeal: A request for your health insurer or plan to review a decision or grievance again.

Appropriate: See the definition of Medically Necessary for the definition of Appropriate as it applies to medical services that are medically necessary.

Authorized Representative: See the Claim Filing and Appeal Information chapter for the definition.

Balance Billing: When a provider bills you for the difference between the provider's charge and the allowed amount. For example, if the provider's charge is $100 and the allowed amount is $70, the provider may bill you for the remaining $30. A preferred provider may **not** balance bill you for covered services.

Behavioral Health Disorder: A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric drugs or medications regardless of any underlying physical or organic cause. Behavioral health disorder includes, among other things, autism, depression, schizophrenia, and substance abuse and treatment that primarily uses psychotherapy or other psychotherapist methods and is provided by Behavioral Health Practitioners as defined in this chapter. Certain Behavioral Health Disorders, conditions and diseases are specifically excluded from coverage as noted in the Medical Plan Exclusions chapter of this document. See also the definitions of Chemical Dependency and Substance Abuse.

Behavioral Health Practitioners: A psychiatrist, psychologist, or a mental health or substance abuse counselor or social worker who has a Master's degree and who is legally licensed and/or legally authorized to practice or provide service, care or treatment of Behavioral Health Disorders under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Behavioral Health Treatment: Behavioral Health Treatment includes all inpatient services, including room and board, given by a Behavioral Health Treatment Facility or area of a Hospital that provides behavioral or mental health or Substance Abuse treatment for a mental disorder identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). If there are multiple diagnoses, only the treatment for the Illness that is identified under the DSM code is considered a Behavioral Health Treatment for the purposes of this Plan.

Behavioral Health Treatment Facility: A specialized facility that is established, equipped, operated and staffed primarily for the purpose of providing a program for diagnosis, evaluation and effective treatment of Behavioral Health Disorders and which fully meets one of the following two tests:

1. It is licensed as a Behavioral Health Treatment Facility by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements: has at least one Physician on staff or on call and provides skilled nursing care by licensed Nurses under the direction of a full-time Registered Nurse (RN) and prepares and maintains a written plan of treatment for each patient based on the medical, psychological and social needs of the patient.

A Behavioral Health Treatment Facility that qualifies as a Hospital is covered by this Plan as a Hospital and not a Behavioral Health Treatment Facility. A residential treatment facility, transitional facility, group home, halfway house or temporary shelter is not a Behavioral Health Treatment Facility under this Plan.

Benefit, Benefit Payment, Plan Benefit: The amount of money payable for a claim, based on the Usual and Customary Charge, after calculation of all Deductibles, Coinsurance and Copayments, and after determination of the Plan's exclusions, limitations and maximums.

Birth (or Birthing) Center: A specialized facility that is primarily a place for delivery of children following a normal uncomplicated pregnancy and which fully meets one of the two following tests:

1. It is licensed by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or

2. Where licensing is not required, it meets all of the following requirements:
   - It is operated and equipped in accordance with any applicable state law for the purpose of providing prenatal care, delivery, immediate post-partum care, and care of a child born at the center.
   - It is equipped to perform routine diagnostic and laboratory examinations, including but not limited to hematocrit and urinalysis for glucose, protein, bacteria and specific gravity, and diagnostic x-rays, or has an arrangement to obtain those services.
   - It has available to handle foreseeable emergencies, trained personnel and necessary equipment, including but not limited to oxygen, positive pressure mask, suction, intravenous equipment, equipment for maintaining infant temperature and ventilation, and blood expanders.
   - It provides at least two beds or two birthing rooms.
   - It is operated under the full-time supervision of a licensed Physician, Registered Nurse (RN) or Certified Nurse Midwife.
   - It has a written agreement with at least one Hospital in the area for immediate acceptance of patients who develop complications.
   - It has trained personnel and necessary equipment to handle emergency situations.
   - It has immediate access to a blood bank or blood supplies.
   - It has the capacity to administer local anesthetic and to perform minor Surgery.
   - It maintains an adequate medical record for each patient that contains prenatal history, prenatal examination, any laboratory or diagnostic tests and a post-partum summary.
   - It is expected to discharge or transfer patients within 48 hours following delivery.

A Birth (or Birthing) Center that is part of a Hospital, as defined in this chapter, will be considered to be a Birth (or Birthing) Center for the purposes of this Plan.

Bitewing X-Rays (Dental): Dental x-rays showing the coronal (crown) halves of the upper and lower teeth when the mouth is closed.

Bridge, Bridgework (Dental): *Fixed:* A prosthesis that replaces one or more teeth and is cemented in place to existing abutment teeth. It consists of one or more Pontics and one or more retainers (Crowns or Inlays). The patient cannot remove the prosthesis. *Removable:* A prosthesis that replaces one or more teeth and which is held in place by clasps. The patient can remove the prosthesis.

Calendar Year: The 12-month period beginning January 1 and ending December 31. For the Medical program, all annual Deductibles and Annual Maximum Plan benefits are determined during the calendar year. For the Dental program Deductibles and Annual Maximum Plan benefits are determined on a calendar year basis.

Cardiac Rehabilitation: Cardiac Rehabilitation refers to a formal program of controlled exercise training and cardiac education under the supervision of qualified medical personnel capable of treating cardiac emergencies, as provided in a hospital outpatient department or other outpatient setting. The goal is to advance the patient to a functional level of activity and exercise without cardiovascular complications in order to limit further cardiac damage and reduce the risk of death. Patients are to continue at home, the exercise and educational techniques they learn in this program. Cardiac rehabilitation services are payable for patients who have had a heart attack (myocardial infarction) or open-heart surgery.

Case Management: A process, administered by the Utilization Management Company, in which its medical professionals work with the patient, family, caregivers, Health Care Providers, Claims Administrator and the Trust Fund to coordinate a timely and cost-effective treatment program. Case Management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential Health Care Providers.

Certified Surgical Assistant: A person who does not hold a valid healthcare license as a RN, Nurse Practitioner (NP), Physician Assistant (PA), Podiatrist, Dentist, MD or DO, and who may or may not be licensed by a state agency and who assists the primary surgeon with a surgical procedure in the operating room and who is not an employee of a health care facility and who bills, commonly as an assistant surgeon. Such individuals may be payable by this Plan (including but not limited to designation as a Certified Surgical Assistant (CSA), Certified Surgical Technologist (CST), Certified First Assistant (CFA), Surgical Technologist (ST), Certified Technical Assistant (CTA), or Certified Operating Room Technician (CORT)), if the use of an assistant surgeon is medically necessary.

Chemical Dependency: This is another term for Substance Abuse. See also the definitions of Behavioral Health Disorders and Substance Abuse.

Child(ren): See the definition of Dependent Child(ren).

Chiropractor: A person who holds the degree of Doctor of Chiropractic (DC); and is legally licensed and authorized to practice the detection and correction, by mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal column (vertebrae); and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Christian Science Practitioner: Christian Science is a system of religious teaching based on an interpretation of Scripture, founded in 1866 by Mary Baker Eddy. It emphasizes full healing of disease by mental and spiritual means. Certain members of the Christian Science church are designated as Christian Science Practitioners who counsel and assist church members in mental and spiritual means to overcome illness based on Christian Science teachings. Christian Science Practitioners are not payable under this Plan.

Claim, Claimant: See the Claim Filing and Appeal Information chapter for the definition.

Claims Administrator: The independent company retained by the Plan to administer the claim processing and payment responsibilities and other administration or accounting services as specific by the Plan. Also called the Administration Office.

Coinsurance: Your share of the costs of a covered healthcare service, calculated as a percent (for example, 20%) of the allowed amount for the service. You pay coinsurance **plus** any deductibles you owe. For example, if the health insurance or plan's allowed amount for an office visit is $100 and you've met your deductible, your coinsurance payment of 20% would be $20. The health insurance or plan pays the rest of the allowed amount.

Complications of Pregnancy: Conditions due to pregnancy, labor and delivery that require medical care to prevent serious harm to the health of the mother or the fetus. Morning sickness and a non-emergency caesarean section aren't complications of pregnancy.

Compound Drugs: See the definition of Prescription Drugs.

Concurrent Care Claim: See the Claim Filing and Appeal Information chapter for the definition.

Concurrent Review: A managed care program designed to assure that Hospitalization and Health Care Facility admissions and length of stay, surgery and other health care services are medically necessary by having the Utilization Management (UM) Company conduct ongoing assessment of the health care as it is being provided, especially (but not limited to) inpatient confinement in a Hospital or Health Care Facility. Also called Continued Stay Review.

Convalescent Care Facility: See the definition of Skilled Nursing Facility.

Coordination of Benefits (COB): The rules and procedures applicable to determination of how Plan benefits are payable when a person is covered by two or more health care plans. See also the Coordination of Benefits chapter.

Copayment, Copay: The fixed dollar amount you are responsible for paying when you incur an Eligible Medical Expense for certain services such as Outpatient prescription drugs. The services with a copay are listed on the Schedule of Medical Benefits in this document.

Corrective Appliances: The general term for appliances or devices that support a weakened body part (Orthotic) or replace a missing body part (Prosthetic). To determine the category of any particular item, see also the definitions of Durable Medical Equipment, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical, dental or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee.

Cost-Efficient: See the definition of Medically Necessary for the definition of Cost-Efficient as it applies to medical services that are medically necessary.

Course of Treatment (Dental): The planned program of one or more services or supplies, provided by one or more Dentists to treat a dental condition diagnosed by the attending Dentist as a result of an oral examination. The course of treatment begins when a Dentist first renders a service to correct or treat the diagnosed dental condition.

Covered Medical and/or Dental Expenses: See the definition of Eligible Medical and/or Dental Expenses.

Crown (Dental): The portion of a tooth covered by enamel. An artificial crown is a dental prosthesis used to return a tooth to proper occlusion, contact and contour, as used as a restoration or an abutment for a fixed prosthesis.

Custodial Care: Care and services given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk (ambulate), or take drugs or medicines that can be self-administered. These services are Custodial Care regardless of where the care is given or who

recommends, provides, or directs the care. Custodial Care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel.

Customary Charge: See the definition of Usual and Customary Charge.

Days (as relates to claim filing and appeals): See the Claim Filing and Appeal Information chapter for the definition.

Deductible: The amount of Eligible Medical Expenses you are responsible for paying before the Plan begins to pay benefits. The amount of deductibles is discussed in the Medical Expense Coverage chapters of this document.

Dental: As used in this document, Dental refers to any services performed by or under the supervision of a Dentist, or supplies, including Dental Prosthetics. Dental includes outpatient prescription drugs prescribed by a dentist, physician or health care practitioner for a dental purpose such as fluoride tablets. Dental services include treatment to alter, correct, fix, improve, remove, replace, reposition, restore or treat: teeth; the gums and tissues around the teeth; the parts of the upper or lower jaws that contain the teeth (the alveolar processes and ridges); the jaw, any jaw implant, or the joint of the jaw (the temporomandibular joint); bite alignment, or the meeting of upper or lower teeth, or the chewing muscles; and/or teeth, gums, jaw or chewing muscles because of pain, injury, decay, malformation, disease or infection. Dental services and supplies are **not covered** under the medical expense coverage of the Plan unless the Plan specifically indicates otherwise in the Schedule of Medical Benefits.

Dental Care Provider: A Dentist, or Dental Hygienist as those terms are specifically defined in this chapter of the document, who is legally licensed and who is a Dentist or performs services under the direction of a licensed Dentist; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dental Subspecialty Areas:

Subspecialty	Services related to the diagnosis, treatment or prevention of diseases related to:
Endodontics	the dental pulp and its surrounding tissues.
Implantology	attachment of permanent artificial replacement of teeth directly to the jaw using artificial root structures.
Oral Surgery	extractions and surgical procedures of the mouth.
Orthodontics	abnormally positioned or aligned teeth.
Pedodontics	treatment of dental problems of children.
Periodontics	structures that support the teeth (gingivae, alveolar bone, periodontal membrane or ligament, cementum).
Prosthodontics	construction of artificial appliances for the mouth (Bridges, Dentures, Crowns).

Dental Hygienist: A person who is trained and legally licensed and authorized to perform dental hygiene services, such as prophylaxis (cleaning of teeth), under the direction of a licensed Dentist, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Dentist: A person holding the degree of Doctor of Dental Surgery (DDS) or Doctor of Dental Medicine (DMD) who is legally licensed and authorized to practice all branches of dentistry under the laws of the state or jurisdiction where the services are rendered; and acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Denture (Dental): A device replacing missing teeth.

Dependent: Any of the following individuals: Dependent Child(ren) or Spouse or Domestic Partner as those terms are defined in this document. See also Eligible Dependent.

Dependent Child(ren):

A. For the purposes of this Plan, a Dependent Child is any of the employee's (but not the Domestic Partner's) unmarried children who have the same principal place of abode as the employee, including a:
   - natural child, stepchild, legally adopted child, or child placed for adoption with the employee, (proof of adoption or placement for adoption may be requested) or
   - child for whom the employee has legal guardianship under a court order (proof of guardianship may be requested); or
   - lawfully placed foster child for whom health coverage is not provided by the State (proof of foster child placement may be requested); or
   - grandchild; provided:

   1. the Dependent Child depends on the employee for **more than one-half of their support** and **is not a "qualifying child" of any other person**.

      The term "qualifying child" is defined in the Internal Revenue Code (IRC) in Section 152 (c). In addition, if a child (for whom the employee is the legal guardian) is not a "relative" as listed in IRC Section 152(d)(2)(A) through (G), the child

must also have the same principal place of abode as the employee for the entire year and be a member of the employee's household; and

2. the child meets **one** of the following criteria:
   a. The child has not reached his or her 26th birthday; or
   b. The child has reached his or her 26th birthday and the child is mentally or physically Handicapped (as that term is defined in this Plan); the child is incapable of self-sustaining employment as a result of that handicap; and that handicap existed before the attainment of this Plan's age limit. This Plan may require initial and periodic proof of handicap. A Dependent Child who is not covered under the Plan but becomes handicapped after reaching the Plan's Dependent age limit is not eligible to enroll as a Dependent under this Plan.

Proof of the same principal place of abode may be requested by the Plan.

B. A child named in a qualified medical child support order (QMCSO) is also an eligible dependent under this Plan. See the Eligibility chapter for details on QMCSOs.

C. A "Domestic Partner Dependent Child(ren)" is a "Dependent Child or Child(ren)" as defined directly above, at heading A. and B of a "Domestic Partner", as defined directly below.

D. See also the Proof of Dependent Status provisions in the Eligibility chapter.

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

F. Coverage of a Dependent Child ends at the end of the month in which that child:
   1. reaches his or her 26th birthday, or
   2. voluntarily or involuntarily terminates full-time attendance at a high school, technical school or institution of higher education or graduates; or
   3. ceases to serve as a full-time missionary; or
   4. marries; or
   5. no longer meets the eligibility requirements of the Plan; or
   6. enters military or similar service anywhere; or
   7. becomes employed on a full-time basis by an employer who participates in the Trust Fund or any other employer where coverage is elected.

   See also the provisions in the Eligibility chapter on "When Coverage Ends."

Disabled: See the definitions of Totally Disabled and Handicapped.

Domestic Partner:

A. Domestic Partners are two adults who have chosen to share one another's lives in an intimate and committed relationship of mutual caring. See also the California Secretary of State website for details on filing a Declaration of Domestic Partnership at http://www.ss.ca.gov/dpregistry/.

B. A domestic partnership is established in California when all of the following requirements are met:
   1. Both persons have a common residence.
   2. Both persons agree to be jointly responsible for each other's basic living expenses incurred during the domestic partnership.
   3. Neither person is married or a member of another domestic partnership.
   4. The two persons are not related by blood in a way that would prevent them from being married to each other in the state of California.
   5. Both persons are at least 18 years of age.
   6. Both persons are capable of consenting to the domestic partnership.
   7. Neither person has previously filed a Declaration of Domestic Partnership with the California Secretary of State pursuant to this division that has not been terminated under section 299.
   8. Both file a Declaration of Domestic Partnership with the California Secretary of State pursuant to this division. See also the California Secretary of State website for details on filing a Declaration of Domestic Partnership at http://www.ss.ca.gov/dpregistry/.

C. "Have a common residence" means that both domestic partners share the same residence. It is not necessary that the legal right to possess the common residence be in both of their names. Two people have a common residence even if one or both have additional residences. Domestic partners do no cease to have a common residence if one leaves the common residence but intends to return.

D. "Basic living expenses" means shelter, utilities and all other costs directly related to the maintenance of the common household of the common residence of the domestic partners. It also means any other cost, such as medical care, if some or all of the cost is paid as a benefit because a person is another person's domestic partner.

E. "Joint responsibility" means that each partner agrees to provide for the other partner's basic living expenses if the partner is unable to provide for herself or himself. Person to whom these expenses are owed may enforce this responsibility if, in extending credit or providing goods or services, they relied on the existence of the domestic partnership and the agreement of both partners to be jointly responsible for those specific expenses.

Durable Medical Equipment (DME): Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an injury or illness; and is not disposable or non-durable and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators. See also the definitions of Corrective Appliances, Nondurable Supplies, Orthotic appliance (or Device) and Prosthetic appliance (or Device).

Elective Hospital Admission, Service or Procedure: Any non-emergency Hospital admission, service or procedure that can be scheduled or performed at the patient's or Physician's convenience without jeopardizing the patient's life or causing serious impairment of body function.

Eligible Dependent: Your lawful Spouse and your Dependent Child(ren), and Domestic Partner. An Eligible Dependent may be enrolled for coverage under the Plan by following the procedures required by the Plan. See the Eligibility chapter for further information. Once an Eligible Dependent is duly enrolled for coverage under the Plan, coverage begins in accordance with the terms and provisions of the Plan, as described in the Eligibility chapter, and that person is a covered Dependent, and remains a covered Dependent until his or her coverage ends in accordance with the terms and provisions of the Plan.

Eligible Medical and/or Dental Expenses: Expenses for medical and/or dental services or supplies, but only to the extent that the expenses meet all of the following qualification as determined by the Plan Administrator or its designee: are medically necessary, as defined in this Definitions chapter; and the charges for them are Usual and Customary, as defined in this Definitions chapter; and coverage for the services or supplies is not excluded; and the Annual Maximum Plan benefits for those services or supplies has not been reached; and are for the diagnosis or treatment of an injury or illness (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document.

Emergency Care: Medical or dental care and treatment provided after the sudden unexpected onset of a medical or dental condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such 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 placing the health of the individual (or in the case of a pregnant woman, the health of her unborn child) in serious jeopardy, serious impairment to bodily functions or serious dysfunction of any bodily organ or part. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Medical Condition: An illness, injury, symptom or condition so serious that a reasonable person would seek care right away to avoid severe harm.

Emergency Medical Transportation: Ambulance services for an emergency medical condition.

Emergency Room Care: Emergency services you get in an emergency room.

Emergency Services: Evaluation of an emergency medical condition and treatment to keep the condition from getting worse.

Emergency Surgery: A surgical procedure performed within 24 hours of the sudden and unexpected severe symptom of an illness or within 24 hours of an accidental injury causing a life-threatening situation.

Employee: Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed by an employer who participates in the Trust Fund and who is eligible to enroll for coverage under the Plan. See the Eligibility provisions in the Eligibility chapter of this document.

Enroll, Enrollment: The process of completing and submitting a written enrollment form indicating that coverage by the Plan is requested by the Employee. An Employee may request coverage for an Eligible Dependent only if he or she is or will be covered by the Plan. See the Eligibility chapter for details regarding the mechanics of enrollment.

Exclusions: Specific conditions, circumstances, and limitations, as set forth in the Exclusions chapters, for which the Plan does **not** provide Plan benefits.

Exhausted (in reference to COBRA Continuation Coverage): For the definition of Exhausted in connection with COBRA Continuation Coverage as it relates to entitlement to Special Enrollment for coverage, see the section on Special Enrollment in the Eligibility chapter.

Experimental and/or Investigational: The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as Experimental and/or Investigational. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, **based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Precertification under the Plan's Utilization Management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:**

1. The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply;
2. The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law;
3. In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical, dental or scientific literature on the subject, or a preponderance of such literature published in the United States; and written by experts in the field; that shows that recognized medical, dental or scientific experts: classify the service or supply as experimental and/or investigational; or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies;
4. With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed; and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. However, a drug will not be considered Experimental and/or Investigational if it is:
    - approved by the FDA as an "investigational new drug for treatment use"; or
    - classified by the National Cancer Institute as a Group C cancer drug when used for treatment of a "life threatening disease" as that term is defined in FDA regulations; or
    - approved by the FDA for the treatment of cancer and has been prescribed for the treatment of a type of cancer for which the drug was not approved for general use, and the FDA has not determined that such drug should not be prescribed for a given type of cancer.
5. The prescribed service or supply is available to the covered person only through participation in Phase I or Phase II clinical trials; **or** Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute or the National Institutes of Health.

In determining if a service or supply is or should be classified as Experimental and/or Investigational, the Plan Administrator or its designee will rely only on the following specific information and resources **that are available at the time the service or supply was performed, provided or considered for Precertification under the Plan's Utilization Management program:**

1. Medical or dental records of the covered person;
2. The consent document signed, or required to be signed, in order to receive the prescribed service or supply;
3. Protocols of the Health Care Provider that renders the prescribed service or prescribes or dispenses the supply;
4. Authoritative peer reviewed medical or scientific writings that are published in the United States regarding the prescribed service or supply for the treatment of the covered person's diagnosis, including, but not limited to "United States Pharmacopeia Dispensing Information"; and "American Hospital Formulary Service";
5. The published opinions of: the American Medical Association (AMA), such as "The AMA Drug Evaluations" and "The Diagnostic and Therapeutic Technology Assessment (DATTA) Program, etc.; or specialty organizations recognized by the AMA; or the National Institutes of Health (NIH); or the Center for Disease Control (CDC); or the Office of Technology Assessment; or the American Dental Association (ADA), with respect to dental services or supplies.
6. Federal laws or final regulations that are issued by or applied to the FDA or Department of Health and Human Services regarding the prescribed service or supply.
7. The latest edition of "The Medicare Coverage Issues Manual."

To determine how to obtain a Precertification of any procedure that might be deemed to be Experimental and/or Investigational, see the Precertification Review section of the Utilization Management chapter.

Extended Care Facility: See the definition of Skilled Nursing Facility.

Federal Legend Drugs: See the definition of Prescription Drugs.

Fluoride (Dental): A solution applied to the surface of teeth or a prescription drug (usually in pill form) to prevent dental decay.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Genetic Counseling: Counseling services provided before or in the absence of Genetic Testing to educate the patient about issues related to chromosomal abnormalities or genetically transmitted characteristics and/or the possible impacts of the results of Genetic Testing; and provided after Genetic Testing to explain to the patient and his or her family the significance of any detected chromosomal abnormalities or genetically transmitted characteristics that indicate either the presence of or predisposition to a disease or disorder of the individual tested, or the presence of or predisposition to a disease or disorder in a fetus of a pregnant woman to allow the patient to make an informed decision.

Genetic Information: Information regarding the presence or absence of chromosomal abnormalities or genetically transmitted characteristics in a person that is obtained from Genetic Testing or that may be inferred from a person's family medical history.

Genetic Testing: Tests that involve the extraction of DNA from an individual's cells and analysis of that DNA to detect the presence or absence of chromosomal abnormalities or genetically transmitted characteristics that indicate the presence of a disease or disorder, the individual's predisposition to a disease or disorder, or the probability that the chromosomal abnormality or characteristic will be transmitted to that person's child, who will then either have that disease or disorder, a predisposition to develop that disease or disorder, or become a carrier of that abnormality or characteristic with the ability to transmit it to future generations.

Grievance: A complaint that you communicate to your health insurer or plan.

Habilitation Services: Health care services that help a person keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who isn't walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/or outpatient settings.

Handicap or Handicapped (Physically or Mentally): The inability of a person to be self-sufficient as the result of a condition such as mental retardation, cerebral palsy, epilepsy or another neurological disorder, psychosis, or is otherwise Totally Disabled, provided the condition was diagnosed by a Physician, and accepted by the Plan Administrator or its designee, as a permanent and continuing condition. See the definition of Totally Disabled.

Health Care Facilities: For the purposes of this Plan, Health Care Facilities include Outpatient Ambulatory Surgical Facilities, Behavioral Health Treatment Facilities, Birthing Centers, Hospices, Skilled Nursing Facilities, and Subacute Care Facilities, as those terms are defined in this Definitions chapter.

Health Care Practitioner: A Physician, Behavioral Health Practitioner, Chiropractor, Dental Hygienist, Dentist, Nurse, Nurse Practitioner, Certified Nurse Midwife, Physician Assistant, Podiatrist, or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, Optometrist, Optician for vision plan benefits, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Health Care Provider: A Health Care Practitioner as defined above, or a Hospital, Ambulatory Surgical Facility, Behavioral Health Treatment Facility, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility, as those terms are defined in this Definitions chapter.

Health Insurance: A contract that requires your health insurer to pay some or all of your health care costs in exchange for a premium.

Home Health Care: Intermittent Skilled Nursing Care services provided by a licensed Home Health Care Agency as those terms are defined in this chapter.

Home Health Care Agency: An agency or organization that provides a program of home health care and meets one of the following three tests:

1. It is approved by Medicare; or
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
    - It has the primary purpose of providing a home health care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or Registered Nurse (RN) to the home.
    - It has a full-time administrator.
    - It is run according to rules established by a group of professional Health Care Providers including Physicians and Registered Nurses (RNs).
    - It maintains written clinical records of services provided to all patients.
    - Its staff includes at least one Registered Nurse (RN) or it has nursing care by a Registered Nurse (RN) available.

- Its employees are bonded.
- It maintains malpractice insurance coverage.

Hospice: An agency or organization that administers a program of palliative and supportive health care services providing physical, psychological, social and spiritual care for terminally ill persons assessed to have a life expectancy of 6 months or less. Hospice care is intended to let the terminally ill spend their last days with their families at home (home Hospice services) or in a home-like setting (Inpatient Hospice), with emphasis on keeping the patient as comfortable and free from pain as possible and providing emotional support to the patient and his or her family. The agency must meet one of the following tests:

1. It is approved by Medicare; or is licensed as a Hospice by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
2. If licensing is not required, it meets all of the following requirements:
   - It provides 24 hour-a-day, 7 day-a-week service.
   - It is under the direct supervision of a duly qualified Physician.
   - It has a full-time administrator.
   - It has a nurse coordinator who is a Registered Nurse (RN) with four years of full-time clinical experience. Two of these years must involve caring for terminally ill patients.
   - The main purpose of the agency is to provide Hospice services.
   - It maintains written records of services provided to the patient.
   - It maintains malpractice insurance coverage.

A Hospice that is part of a Hospital, as defined in this chapter, will be considered a Hospice for the purposes of this Plan.

Hospital: A public or private facility or institution, licensed and operating according to law, that:

1. is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO); and
2. is approved by Medicare as a Hospital; and
3. provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises.

A hospital may include facilities for Behavioral Health treatment that are licensed and operated according to law. Any portion of a Hospital used as an Ambulatory Surgical Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Subacute Care Facility, or other residential treatment facility or place for rest, Custodial Care, or the aged will **not** be regarded as a Hospital for any purpose related to this Plan.

Hospital Outpatient Care: Care in a hospital that usually doesn't require an overnight stay.

Hospitalization: Care in a hospital that requires admission as an inpatient and usually requires an overnight stay. An overnight stay for observation could be outpatient care.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition. **Pregnancy of a Member or Dependent Spouse will be considered to be an Illness only for the purpose of coverage under this Plan.**

Impression (Dental): A negative reproduction of the teeth and gums, from which models of the jaws are made. These models are used to study certain conditions and to make dental appliances and prostheses.

Inherited Metabolic Disorder: A genetically acquired disorder of metabolism involving the inability to properly metabolize amino acids, carbohydrates or fats, as diagnosed by a Physician using standard blood, urine, spinal fluid, tissue or enzyme analysis. Inherited metabolic disorders are also referred to as inborn errors of metabolism and include Phenylketonuria (PKU), Maple Syrup Urine Disease, Homocystinuria and Galactosemia. Lactose intolerance without a diagnosis of Galactosemia and diabetes are not inherited metabolic disorders under this Plan. See also Medical Foods.

Injury: Any damage to a body part resulting from trauma from an external source. Note the Plan's exclusion for treatment of an injury that is work-related and the exclusion for services that are not covered by the Plan.

Injury to Teeth: An injury to the teeth caused by trauma from an external source. This **does not include** an injury to the teeth caused by any intrinsic force, such as the force of biting or chewing. Benefits for Accidental Injury to Teeth may be payable under Oral services in the Schedule of Medical Benefits.

Inlay (Dental): A Restoration made to fit a prepared tooth cavity and then cemented into place. See the definition of Restoration.

In-Network Coinsurance: The percent (for example, 20%) you pay of the allowed amount for covered health care services to providers who contract with your health insurance or plan. In-network coinsurance usually costs you less than out-of-network coinsurance.

In-Network Copayment: A fixed amount (for example, $10) you pay for covered health care services to providers who contract with your health insurance or plan. In-network copayments usually are less than out-of-network copayments.

In-Network Services: Services provided by a Health Care Provider that is a member of the Plan's Preferred Provider Organization (PPO), as distinguished from Out-of-Network Services that are provided by a Health Care Provider that is **not** a member of the PPO.

Inpatient Services: Services provided in a Hospital or other Health Care Facility during the period when charges are made for room and board.

Investigational: See the definition of Experimental and/or Investigational.

Maintenance Care: Services and supplies provided primarily to maintain, support and/or preserve a level of physical or mental function rather than to improve such function.

Managed Care: Procedures designed to help control health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result.

Maximum Plan Benefits: The maximum amount of benefits payable by the Plan (and described more fully in the Medical Expense Coverage chapter of this document) on account of medical expenses incurred by any covered Plan Participant.

- **Annual Maximum Plan Benefits** are the maximum amount of benefits payable each Calendar Year on account of certain medical expenses incurred by any covered Plan Participant or family of the Plan Participant under this Plan.

Medical Foods: Modified low protein foods and metabolic formulas as described here:

- Modified Low Protein foods are foods that are formulated to be consumed or administered through the gastrointestinal tract and are processed or formulated to contain less than one gram of protein per unit of serving and are administered for the medical and nutritional management of a person who has limited ability to properly metabolize food or nutrients and such medical food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder.
- Metabolic Formulas are solutions consumed or administered through the gastrointestinal tract and are processed or formulated to be deficient in one or more nutrients present in typical food products and are administered because a person has limited ability to properly metabolize food or nutrients and such medical food is essential to the person's growth, health and metabolic homeostasis and are administered under the direction of a Physician for a person who has an inherited metabolic disorder. See the definition of inherited metabolic disorder.
- Medical Foods are NOT natural foods low in protein and/or galactose, spices, flavorings, or foods or formulas required by persons who do not have inherited metabolic disorders as that term is defined in this document.

Medically Necessary:

A. A medical or dental service or supply will be determined to be **"Medically Necessary"** by the Plan Administrator or its designee if it:
   1. is provided by or under the direction of a Physician or other duly licensed Health Care Practitioner who is authorized to provide or prescribe it or Dentist if a dental service or supply is involved; and
   2. is determined by the Plan Administrator or its designee to be necessary in terms of generally accepted American medical and dental standards; and
   3. is determined by the Plan Administrator or its designee to meet <u>all</u> of the following requirements:
      - It is consistent with the symptoms or diagnosis and treatment of an illness or injury; and
      - It is not provided solely for the convenience of the patient, Physician, Dentist, Hospital, Health Care Provider, or Health Care Facility; and
      - It is an **"Appropriate"** service or supply given the patient's circumstances and condition; and
      - It is a **"Cost-Efficient"** supply or level of service that can be safely provided to the patient; and
      - It is safe and effective for the illness or injury for which it is used.

B. A medical or dental service or supply will be considered to be **"Appropriate"** if:
   1. It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

2. It is care or treatment that is as likely to produce a significant positive outcome as and no more likely to produce a negative outcome than any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

C. A medical or dental service or supply will be considered to be **"Cost-Efficient"** if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.

D. The fact that your Physician or Dentist may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical or dental coverage provided by the Plan.

E. A Hospitalization or confinement to a Health Care Facility will not be considered to be medically necessary if the patient's illness or injury could safely and appropriately be diagnosed or treated while not confined.

F. A medical or dental service or supply that can safely and appropriately be furnished in a Physician's or Dentist's office or other less costly facility will not be considered to be medically necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

G. The non-availability of a bed in another Health Care Facility, or the non-availability of a Health Care Practitioner to provide medical services will not result in a determination that continued confinement in a Hospital or other Health Care Facility is medically necessary.

H. A medical or dental service or supply will not be considered to be medically necessary if it does not require the technical skills of a Dental or Health Care Practitioner or if it is furnished mainly for the personal comfort or convenience of the patient, the patient's family, any person who cares for the patient, any Dental or Health Care Practitioner, Hospital or Health Care Facility.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act as it is now amended and as it may be amended in the future.

Member: means an employee or retiree but not their spouse or dependent children.

Mental Disorder; Mental and Nervous Disorder: See the definition of Behavioral Health Disorder.

Midwife, Certified Nurse Midwife: A person legally licensed as a certified nurse midwife in the area of managing the care of mothers and babies throughout the maternity cycle, as well as providing general gynecological care, including history taking, performing physical examinations, ordering laboratory tests and x-ray procedures, managing labor, delivery and the post-delivery period, administer intravenous fluids and certain medications, provide emergency measures while awaiting aid, perform newborn evaluation, sign birth certificates, and bill and be paid in his or her own name, and who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. A Midwife may not independently manage moderate or high-risk mothers, admit to a hospital, or prescribe all types of medications.

Naturopathy: A therapeutic system based on principles of treating diseases with natural forces such as water, heat, diet, sunshine, stress reduction, physical manipulation, massage or herbal tea.

Network: The facilities, providers and suppliers your health insurer or plan has contracted with to provide health care services.

Nondurable Supplies: Goods or supplies that cannot withstand repeated use and/or that are considered disposable and limited to either use by a single person or one-time use, including, but not limited to, bandages, hypodermic syringes, diapers, soap or cleansing solutions, etc. See also the definitions of Corrective Appliances, Durable Medical Equipment, Orthotic appliance (or Device) and Prosthetic appliance (or Device). Only those nondurable supplies identified in the Schedule of Medical Benefits are covered by this Plan. All others are not.

Non-Network: See Out of Network.

Non-Participating Provider: A Health Care Provider who **does not participate** in the Plan's Preferred Provider Organization (PPO).

Nurse: A person legally licensed as a Registered Nurse (RN), Certified Registered Nurse Anesthetist (CRNA), Certified Nurse Midwife, Nurse Practitioner (NP), Licensed Practical Nurse (LPN), Licensed Vocational Nurse (LVN), Psychiatric Mental Health Nurse, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Anesthetist: A person legally licensed as a Certified Registered Nurse Anesthetist (CRNA), Registered Nurse Anesthetist (RNA) or Nurse Anesthetist (NA), and authorized to administer anesthesia in collaboration with a Physician, and bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, who acts within the scope of his or her license; and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Nurse Practitioner: A person legally licensed as a Nurse Practitioner (NP), Family Nurse Practitioner (FNP) or Registered Nurse Practitioner (RNP) who acts within the scope of his or her license and who in collaboration with a Physician, examines patients, establishes medical diagnoses; orders, performs and interprets laboratory, radiographic and other diagnostic tests, identifies, develops, implements and evaluates a plan of patient care, prescribes and dispenses medication, refers to and consults with appropriate Health Care Practitioners and bills and is able to be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Occupational Therapist: A person legally licensed as a professional occupational therapist who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to assess the presence of defects in an individual's ability to perform self-care skills and activities of daily living and who formulates and carries out a plan of action to restore or support the individual's ability to perform such skills in order to regain independence.

Office Visit: A direct personal contact between a Physician or other Health Care Practitioner and a patient in the Health Care Practitioner's office for diagnosis or treatment associated with the use of the appropriate office visit code in the Current Procedural Terminology (CPT) manual of the American Medical Association or the Current Dental Terminology (CDT) manual of the American Dental Association and with documentation that meets the requirement of such CPT or CDT coding. Neither a telephone discussion with a Physician or other Health Care Practitioner, internet/virtual office visit, nor a visit to a Health Care Practitioner's office solely for such services as blood drawing, leaving a specimen, or receiving a routine injection is considered to be an Office Visit for the purposes of this Plan.

Onlay (Dental): An Inlay Restoration that is extended to cover the biting surface of the tooth, but not the entire tooth. It is often used to restore lost and weakened tooth structure.

Open Enrollment Period: The period during which participants in the Plan may select among the alternate health benefit programs that are offered by the Plan or eligible individuals not currently enrolled in the Plan may enroll for coverage. The Plan's annual Open Enrollment Period is described in the Eligibility chapter of this document.

Orthodontics, Orthodontia: The science of the movement of teeth in order to correct a malocclusion or "crooked teeth."

Orthognathic Services: Services dealing with the cause and treatment of malposition of the bones of the jaw, such as to shorten or lengthen the horizontal, vertical or transverse dimensions of the jaw so that facial soft tissue, teeth and/or other facial structures are in aesthetic alignment/balance. Malposition can produce conditions such as Prognathism, Retrognathism, or TMJ syndrome/dysfunction. See the definitions of Prognathism, Retrognathism, and TMJ syndrome/dysfunction.

Orthotic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does **not** include Dental Orthotics. See also the definitions of Corrective Appliance, Durable Medical Equipment, Nondurable Supplies and Prosthetic appliance (or Device).

Out-of-Network Coinsurance: The percent (for example, 40%) you pay of the allowed amount for covered health care services to providers who do **not** contract with your health insurance or plan. Out-of-network coinsurance usually costs you more than in-network coinsurance.

Out-of-Network Copayment: A fixed amount (for example, $30) you pay for covered health care services from providers who do **not** contract with your health insurance or plan. Out-of-network copayments usually are more than in-network copayments.

Out-of-Pocket Limit: The most you pay during a policy period (usually a year) before your health insurance or plan begins to pay 100% of the allowed amount. The limit never includes your premium, balance-billed charges or health care your health insurance or plan doesn't cover. Some health insurance or plans don't count all of your copayments, deductibles, coinsurance payments, out-of-network payments or other expenses toward this limit.

Out-of-Network Services (Non-network): Services provided by a Health Care Provider that is **not** a member of the Plan's Preferred Provider Organization (PPO), as distinguished from In-Network Services that are provided by a Health Care Provider that is a member of the PPO.

Outpatient Services: Services provided either outside of a hospital or Health Care Facility setting or at a hospital or Health Care Facility when room and board charges are **not** incurred.

Partial Denture (Dental): A Prosthesis that replaces one or more, but less than all, of the natural teeth and associated structures. The denture may be removable or fixed.

Participant: Any Member and/or Retiree and that person's eligible Spouse or Dependent Child or Domestic Partner (as these terms are defined in the Plan) who has completed all required formalities for enrollment for coverage under the Plan and is actually covered by the Plan.

Participating Provider: A Health Care Provider who participates in the Plan's Preferred Provider Organization (PPO).

Pharmacist: A person legally licensed under the laws of the state or jurisdiction where the services are rendered, to prepare, compound and dispense drugs and medicines, and who acts within the scope of his or her license.

Physical Therapist: A person legally licensed as a professional physical therapist who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of a physician to perform physical therapy services including the evaluation, treatment and education of a person using physical measures, therapeutic exercise, thermal (hot/cold) techniques and/or electrical stimulation to correct or alleviate a physical disability.

Physical Therapy: Rehabilitation directed at restoring function following disease, injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Physician Assistant (PA): A person legally licensed as a Physician Assistant, who acts within the scope of his or her license and acts under the supervision of a Physician to examine patients, establish medical diagnoses; order, perform and interpret laboratory, radiographic and other diagnostic tests; identify, develop, implement and evaluate a plan of patient care; prescribe and dispense medication within the limits of his or her license; refer to and consult with the supervising Physician; and bill and be paid in his or her own name under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Physician Services: Health care services a licensed medical physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) provides or coordinates.

Placed for Adoption: For the definition of Placed for Adoption as it relates to coverage of adopted Dependent children, see the definition in the section on Adopted Dependent Children in the Eligibility chapter.

Plan, This Plan: The programs, benefits and provisions described in this document. A benefit your employer, union or other group sponsor provides to you to pay for your health care services.

Plan Administrator: The Board of Trustees who has the fiduciary responsibility for the overall administration of the Plan.

Plan Participant: The eligible employee, retiree, domestic partner or dependent who has enrolled for coverage under the Plan.

Plan Year: The twelve-month period from January 1 to December 31 designated to be the Plan Year. See also the definitions of Calendar Year.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient.

Pontic (Dental): The part of a fixed bridge that is suspended between two abutments and replaces a missing tooth.

Post-service Claim: See the Claim Filing and Appeal Information chapter for the definition.

Pre-Admission Testing: Laboratory tests and x-rays and other medically necessary tests performed on an outpatient basis prior to a scheduled hospital admission or outpatient surgery.

Preauthorization: A decision by your health insurer or plan that a health care service, treatment plan, prescription drug or durable medical equipment is medically necessary. Sometimes called prior authorization, prior approval or precertification. Your health insurance or plan may require preauthorization for certain services before you receive them, except in an emergency. Preauthorization isn't a promise your health insurance or plan will cover the cost.

Precertification: Precertification is a review procedure performed by the Utilization Management Company **before** services are rendered, to assure that health care services meet or exceed accepted standards of care and that the service, admission and/or length of stay in a health care facility is appropriate and medically necessary.

Preferred Provider: A provider who has a contract with your health insurer or plan to provide service to you at a discount. Check your policy to see if you can see all preferred providers or if your health insurance or plan has a "tiered" network and you must pay extra to see some providers. Your health insurance or plan may have preferred providers who are also "participating"

providers. Participating providers also contract with your health insurer or plan, but the discount may not be as great, and you may have to pay more.

Preferred Provider Organization (PPO): An independent group or network of Health Care Providers (*e.g.* hospitals, physicians, laboratories) under contract with the Plan to provide health care services and supplies at agreed-upon discounted/reduced rates.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drugs:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Other Prescription Drugs:** Drugs that require a prescription under state law but not under federal law.
3. **Compound Drugs:** Any drug that has more than one ingredient and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law.

Pre-service Claim: See the Claim Filing and Appeal Information chapter for the definition.

Prevailing Charge: See the definition of Usual and Customary for the definition of Prevailing Charge as it relates to the determination that a Health Care Provider's charge is Usual and Customary.

Primary Care Physician: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine) who directly provides or coordinates a range of health care services for a patient.

Primary Care Provider: A physician (M.D. – Medical Doctor or D.O. – Doctor of Osteopathic Medicine), nurse practitioner, clinical nurse specialist or physician assistant, as allowed under state law, who provides, coordinates or helps a patient access a range of health care services.

Prognathism: The malposition of the bones of the jaw resulting in projection of the lower jaw beyond the upper part of the face. See also Orthognathic.

Prophylaxis (Dental): The removal of tartar and stains from the teeth. The cleaning and scaling of the teeth is performed by a Dentist or Dental Hygienist.

Prosthesis (Dental): An artificial replacement of one or more natural teeth and/or associated structures.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs, heart pacemakers, or corrective lenses needed after cataract surgery. See also the definitions of Corrective Appliances, Durable Medical Equipment, Nondurable Supplies and Orthotic appliance (or Device).

Provider: See the definition of Health Care Provider.

Qualified Medical Child Support Order (QMCSO): A court order that complies with requirements of federal law requiring an employee to provide health care coverage for a Dependent Child and requiring that benefits payable on account of that Dependent Child be paid directly to the Health Care Provider who rendered the services or to the custodial parent of the Dependent Child. See also the Eligibility chapter of this document.

Reconstructive Surgery: A medically necessary surgical procedure performed on an abnormal or absent structure of the body to correct damage caused by a congenital birth defect, an accidental injury, infection, disease or tumor, or for breast reconstruction following a total or partial mastectomy.

Rehabilitation Therapy: Physical, occupational, or speech therapy that is prescribed by a Physician when the bodily function has been restricted or diminished as a result of illness, injury or surgery, with the goal of improving or restoring bodily function by a significant and measurable degree to as close as reasonably and medically possible to the condition that existed before the injury, illness or surgery, and that is performed by a licensed therapist acting within the scope of his or her license. See the Schedule of Medical Benefits and the Exclusions chapter of this document to determine the extent to which Rehabilitation Therapies are covered. See also the definition of Physical Therapy, Occupational Therapy, Speech Therapy, and Cardiac Rehabilitation.

1. **Active Rehabilitation** refers to therapy in which a patient, who has the ability to learn and remember, **actively participates** in the rehabilitation that is intended to provide significant and measurable improvement of an individual who is restricted and cannot perform normal bodily function.
2. **Maintenance Rehabilitation** refers to therapy in which a patient actively participates, that is provided after a patient has met the functional goals of Active Rehabilitation so that no continued significant and measurable improvement is reasonably and medically anticipated, but where additional therapy of a less intense nature and decreased frequency may reasonably be prescribed to maintain, support, and/or preserve the patient's functional level. **Maintenance Rehabilitation is not covered by the Plan.**

3. **Passive Rehabilitation** refers to therapy in which a patient does **not** actively participate because the patient does not have the ability to learn and/or remember (that is, has a cognitive deficit), or is comatose or otherwise physically or mentally incapable of active participation. Passive Rehabilitation may be covered by the Plan, but only during a course of Hospitalization for acute care. Techniques for passive rehabilitation are commonly taught to the family/caregivers to employ on an outpatient basis with the patient when and until such time as the patient is able to achieve active rehabilitation. **Continued Hospitalization for the sole purpose of providing Passive Rehabilitation will not be considered to be medically necessary for the purposes of this Plan.**

Restoration (Dental): A broad term applied to any filling, crown, bridge, partial denture or complete denture that restores or replaces loss of tooth structure, teeth or oral tissue. The term applies to the end result of repairing and restoring or reforming the shape and function of part or all of the tooth or teeth.

Retiree: is defined in the Eligibility chapter of this document**.**

Retrognathism: The malposition of the bones of the jaw resulting in the retrogression of the lower jaw from the upper part of the face. See also Orthognathic.

Retrospective Review: Review of health care services **after** they have been provided to determine if those services were medically necessary and/or if the charges for them are Usual and Customary Charges.

Root Canal (Endodontic) Therapy (Dental): Treatment of a tooth having a damaged pulp. The treatment is usually performed by completely removing the pulp, sterilizing the pulp chamber and root canals, and filling these spaces with a sealing material.

Scale (Dental): To remove calculus (tartar) and stains from the teeth with special instruments.

Second Opinion: A consultation and/or examination, preferably by a board-certified Physician not affiliated with the primary attending Physician, to evaluate the medical necessity and advisability of undergoing surgery or receiving a medical service.

Skilled Nursing Care: Services performed by a licensed nurse (RN, LVN or LPN) if the services are ordered by and provided under the direction of a Physician; and are intermittent and part-time, generally not exceeding 16 hours a day, and are usually provided on less-than-daily basis; and require the skills of a nurse because the services are so inherently complex that they can be safely and effectively performed only by or under the supervision of a nurse. Examples of Skilled Nursing Care services include, but are not limited to, the initiation of intravenous therapy and the initial management of medical gases such as oxygen.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and
7. It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Specialist: A physician specialist focuses on a specific area of medicine or a group of patients to diagnose, manage prevent or treat certain types of symptoms and conditions. A non-physician specialist is a provider who has more training in a specific area of health care.

Specialty Care Unit: A section, ward, or wing within a hospital that offers specialized care for the patient's needs. Such a unit usually provides constant observation, special supplies, equipment, and care provided by Registered Nurses or other highly trained personnel. Examples include Intensive Care Units (ICU) and Cardiac Care Units (CCU).

Speech Therapist: A person legally licensed as a professional speech therapist who acts within the scope of their license and who is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient, and acts under the direction of

a physician to perform speech therapy services including the application of principles, methods and procedures for the measurement, testing, evaluation, prediction, counseling, instruction, or rehabilitation related to disorders of speech, voice, language, swallowing or feeding.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to **restore** normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to illness, injury or surgical procedure. Speech therapy for functional purposes, including but not limited to a speech impediment, stuttering, lisping, tongue thrusting, stammering, conditions of psychoneurotic origin or childhood developmental speech delays/disorders are excluded from coverage.

Spinal Manipulation: The detection and correction, by manual or mechanical means, of the interference with nerve transmissions and expressions resulting from distortion, misalignment or dislocation of the spinal (vertebrae) column. Spinal Manipulation is commonly performed by Chiropractors, but it can be performed by Physicians.

Spouse: The Member's or Retiree's lawful spouse as determined by the laws of the state where the Member or Retiree resides. The Plan may require proof of the legal marital relationship. A legally separated spouse or domestic partner or divorced former spouse of a Member or Retiree is not an eligible Spouse under this Plan.

Subacute Care Facility: A public or private facility, either free-standing, Hospital-based or based in a Skilled Nursing Facility, licensed and operated according to law and authorized to provide Subacute Care, that primarily provides, immediately after or instead of acute care, comprehensive inpatient care for an individual who has had an acute illness, injury, or exacerbation of a disease process, with the goal of discharging the patient after a limited term of confinement to the patient's home or to a suitable Skilled Nursing Facility, and that meets **all** of the following requirements:

1. It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Subacute Care Facility or is recognized by Medicare as a Subacute Care Facility; and
2. It maintains on its premises all facilities necessary for medical care and treatment; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse; and
5. It is not (other than incidentally) a place for rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or suffering from tuberculosis; and
6. It is not a hotel or motel.

Subrogation: This is a technical legal term for the right of one party to be substituted in place of another party in a lawsuit. See the Third Party Liability subchapter in the chapter on Coordination of Benefits for an explanation of how the Plan may use the right of subrogation to be substituted in place of a Participant in that person's claim against a third party who wrongfully caused that person's injury or illness, so that the Plan may recover medical and/or dental benefits paid if the Participant recovers any amount from the third party either by way of a settlement or judgment in a lawsuit. See also the definition of Tortfeasor.

Substance Abuse: A psychological and/or physiological dependence or addiction to alcohol or drugs or medications, regardless of any underlying physical or organic cause, and/or other drug dependency as defined by the current edition of the ICD manual or identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM). See the definitions of Behavioral Health Disorders and Chemical Dependency.

Surgery: Any operative or diagnostic procedure performed in the treatment of an injury or illness by instrument or cutting procedure through an incision or any natural body opening. When more than one surgical procedure is performed through the same incision or operative field or at the same operative session, the Plan Administrator or its designee will determine which surgical procedures will be considered to be separate procedures and which will be considered to be included as a single procedure for the purpose of determining Plan benefits. When the procedures will be considered to be separate procedures, the following percentages of the Usual and Customary Charge will be allowed as the Plan's benefit:

1. Allowances for multiple surgeries through the same incision or operational field:

Primary procedure	100% of U & C Charge
Secondary and additional procedures	50% of U & C Charge per procedure

2. Allowances for multiple surgeries through separate incisions or operative fields performed at the same operative session:

First site primary procedure	100% of U & C Charge
First site secondary and additional procedures	50% of U & C Charge per procedure
Second site primary and additional procedures	50% of U & C Charge per procedure

Surgical Assistant: See Certified Surgical Assistant.

Temporomandibular Joint (TMJ), Temporomandibular Joint (TMJ) Dysfunction or Syndrome: The temporomandibular (or craniomandibular) joint (TMJ) connects the bone of the temple or skull (temporal bone) with the lower jawbone (the mandible). TMJ dysfunction or syndrome refers to a variety of symptoms where the cause is not clearly established, including, but not limited to, masticatory muscle disorders producing severe aching pain in and about the TMJ (sometimes made worse by chewing or talking), myofacial pain (pain in the muscles of the face), headaches, earaches, limitation of the joint, clicking sounds during chewing, tinnitus (ringing, roaring or hissing in one or both ears) and/or hearing impairment. These symptoms may be associated with conditions such as malocclusion (failure of the biting surfaces of the teeth to meet properly), ill-fitting dentures, or internal derangement of the TMJ.

Therapist: A person trained and skilled in giving therapy in a specific field of health care such as occupational, physical, radiation, respiratory and speech therapy who is legally licensed to perform such services (where licensing required by State law) and who works within the scope of his or her license and provides services under the direction of a Physician, is allowed to bill and be paid in his or her own name, or any equivalent designation, under the laws of the state or jurisdiction where the services are rendered, and is not the patient or the parent, spouse, sibling (by birth or marriage) or child of the patient. For further information, see the definition of Occupational, Physical and Speech Therapy.

Topical (Dental): Painting the surface of teeth as in a fluoride treatment or application of a cream-like anesthetic formula to the surface of the gum.

Tort, Tortfeasor: A civil wrong or injury, typically arising negligent or intentional act of an individual, who is called a tortfeasor. See also the definition of Subrogation.

Total Disability, Totally Disabled: The inability of a Member to perform all the duties of his or her occupation as a result of a non-occupational illness or injury, or the inability of a 27Dependent to perform the normal activities or duties of a person of the same age and sex. See also the definition of Handicap.

Transplant, Transplantation: The transfer of organs (such as the heart, kidney, liver) or living tissue/cells (such as bone marrow, stem cells or skin) from a donor to a recipient with the intent to maintain the functional integrity of the transplanted organ or tissue in the recipient.

- **Autologous** refers to transplants of organs, tissues or cells from one part of the body to another. Bone marrow and skin transplants are often autologous.
- **Allogenic** refers to transplants of organs, tissues or cells from one person to another person. Heart transplants are allogenic.
- **Xenographic/xenotransplant** refers to transplantation, implantation or infusion of organs, tissues or cells from one species to another (for example, the transplant of an organ from an animal to a human). Expenses related to xenographic services are **not** covered by this Plan.

See the Schedule of Medical Benefits and the Exclusions chapter for additional information regarding Transplants. See also the Utilization Management chapter of this document for information about precertification requirements for transplantation services.

Urgent Care: Health care services that are required by the onset of a medical condition that manifests itself by symptoms of sufficient severity that prompt medical attention is appropriate even though health and life is **not** in jeopardy. Examples of medical conditions that may be appropriate for Urgent Care include, but are not limited to, fever, sprains, bone or joint injuries, continuing diarrhea or vomiting, or bladder infections.

Urgent Care Claim: See the Claim Filing and Appeal Information chapter for the definition.

Urgent Care Facility: A public or private Hospital-based or free-standing facility that is licensed or legally operating as an Urgent Care Facility, that primarily provides minor Emergency and episodic medical care, in which one or more Physicians, Nurses, and x-ray technicians are in attendance at all times when the facility is open, and that includes x-ray and laboratory equipment and a life support system.

Usual and Customary Charge (U&C): The charge for medically necessary services or supplies will be determined by the Plan Administrator or its designee to be the **lowest** of:

1. With respect to a PPO Health Care or Dental Care Provider, the fee set forth in the agreement between the PPO Provider and the PPO or the Plan; **or**
2. For medical benefits, no more than the 90th percentile of Ingenix (formerly called HIAA or MDR), a national schedule of prevailing health care charges (defined below), updated annually; or for dental benefits no more than the 90th percentile of Ingenix, a national schedule of prevailing dental care charges (defined below), updated annually; **or**
3. The Health Care or Dental Care Provider's actual charge; **or**
4. The usual charge by the Health Care or Dental Care Provider for the same or similar service or supply.

The **"Prevailing Charge"** of most other Health Care or Dental Care Providers in the same or similar geographic area for the same or similar health care service or supply will be determined by the Claims Administrator using proprietary data that is provided by a reputable company or entity and is updated no less frequently than annually.

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 Usual and Customary charge for health care services or supplies.

- **Any amount in excess of the Usual and Customary Charge is not payable by the Plan.** Participants are responsible for amounts that exceed UCR allowances payable by this Plan.
- The Usual and Customary Charge is sometimes referred to as the U & C Charge, reasonable and customary charge, R & C charge, usual, customary and reasonable charge, or UCR charge.

Utilization Management (UM): A managed care procedure to determine the Medical Necessity, appropriateness, location, and cost-effectiveness of health care services. This review can occur before, during or after the services are rendered and may include, but is not limited to, Precertification and/or preauthorization; Concurrent and/or continued stay review; Discharge planning; Retrospective review; Case Management; Hospital or other Health Care Provider bill audits; and Health Care Provider fee negotiation. Utilization Management services (sometimes referred to as UM services, UM program, Utilization Review services, UR services, Utilization Management and Review services, or UMR services) are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan.

Utilization Management Company: The independent utilization management organization, staffed with licensed health care professionals, who utilize nationally recognized health care screening criteria along with the medical judgment of their licensed health care professional, operating under a contract with the Plan to administer the Plan's Utilization Management services.

Visit: See the definition of Office Visit.

You, Your: When used in this document, these words refer to the employee who is covered by the Plan. They do **not** refer to any Dependent of the employee.

Website: www.southbayheretrust.com
Telephone: (408) 321-9700 or (800) 544-5085