CALIFORNIA IRONWORKERS FIELD WELFARE PLAN

Summary Plan Description/Plan Document

for

Active Employees and Their Eligible Dependents

Effective September 1, 2016

IMPORTANT NOTE

This document, together with the Evidence of Coverage issued by Kaiser Permanente, Health Plan of Nevada, Assurant Employee Benefits; DeltaCare, USA; Health Net Dental; or United Concordia is your Summary Plan Description (SPD). If the Evidence of Coverage is not attached, then the Summary Plan Description is not complete and you should contact the Trust Fund Office for a complete SPD

California Ironworkers Field Welfare Plan for Active Employees and Their Eligible Dependents

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Introduction

California Ironworkers Field Welfare Plan

We are pleased to provide you with this ***Summary Plan Description/Plan Document*** (hereafter referred to as the "SPD") that describes the benefits provided by the California Ironworkers Field Welfare Plan as of September 1, 2016. This document replaces and supersedes all prior ***SPDs*** previously sent to you. As an active participant in the California Ironworkers Field Welfare Plan, you are eligible for a wide range of benefits:

- Medical
- Prescription Drug
- Mental Health and Substance Abuse Treatment
- Dental
- Vision
- Life, Dependent Life, and Accidental and Death

Each calendar year prior to the annual open enrollment period, you are provided written materials explaining your enrollment options for the upcoming year. These may be considered as Summaries of Material Modifications to this Plan. In this case, you need to review this SPD in combination with the open enrollment material for an accurate description of your benefits.

Please refer to the Schedule of Medical Benefits for a detailed comparison and description of the Fee for Service medical plan benefits (including prescription drugs and mental health/substance abuse treatment) for the Active Plan, Z-Coverage and the A-Rodman Plan. After you meet the eligibility requirements of the Fund, you (and any covered Dependents) will be eligible for the Active Plan coverage (unless your employer has elected to report less than the full hourly health and welfare contribution). Please contact the Trust Fund Office if you have questions regarding your plan of coverage.

Not all plan options may be available for all active participants and their Dependents as choices are based on your applicable Collective Bargaining Agreement and your state of residence.

About This SPD

If you enroll in the Fee-for-Service medical plan, you will automatically be enrolled in the Fee-for-Service prescription drug plan, both of which are described in more detail in this ***SPD***. If you enroll in the Kaiser HMO or the Health Plan of Nevada HMO, all of your medical and prescription drug benefits, (including all procedures you should follow if you are dissatisfied with the handling of your claims), are described solely in the *Evidence of Coverage* booklet you will receive directly from the HMO.

The Fee-for-Service medical plan is funded directly by the Trust Fund and is not fully-insured. Medical benefits are provided through an Anthem Blue Cross of California Preferred Provider Organization (PPO) network that is administered by the Trust Fund Office. In addition, the Trustees have entered into a service agreement with EnvisionRx to manage the prescription drug plan.

Please take special note of the Plan's medical management programs for the Fee-for-Service medical plan, which include:

- Pre-Authorization by Anthem Blue Cross for inpatient hospital admissions (except for emergencies and certain maternity confinements) and other services;
- Pre-Authorization by Managed Health Network (MHN) for inpatient mental health and substance abuse admissions (except for emergencies) and other services;

- Pre-Authorization by Pacific Health Alliance (PHA) for outpatient surgeries, procedures, and various other services; and
- Pre-authorization by EnvisionRx for non-formulary brand name prescription drugs. These programs were implemented to help provide you with quality health care and to also help control medical cost inflation.

Managed Health Network (MHN) provides access to substance abuse and mental health providers and oversees the management of those services. **Please note: covered Dependents of Active Employees are not eligible for substance abuse benefits** (except for certain preventive screenings required under the Affordable Care Act).

If you enroll in the Fee-for-Service dental plan, your benefits will be administered by Delta Dental and are described in this ***SPD***. Depending on the state that you live in and the plan option governed by your Collective Bargaining Agreement, you may have the option of enrolling in a dental HMO provided by one of the following:

- Assurant Employee Benefits; or
- DeltaCare, USA; or
- Health Net Dental; or
- United Concordia.

If you enroll in an HMO dental plan, your dental benefits are explained in the *Evidence of Coverage (EOC)* you will receive from your dental plan.

Although these benefits are funded directly by the Trust Fund from contributions made by signatory Employers, the Trustees rely on these service providers to determine Allowed Charges and make decisions regarding Medical Necessity of services. If you are dissatisfied with an initial claim decision made by one of these service providers, you may seek assistance through the customer service process that each of the service providers has in place. The Trust Fund Office will assist you with any such customer service process with a service provider. If you cannot resolve an issue directly with the service provider, you may make an appeal directly to the Board of Trustees as described in the *Claims Procedures and Appeals* section of this ***SPD***. However, please be aware that if you wish to file a formal appeal with the Board of Trustees, you must do so within the timeframes noted beginning on page 87.

On the following pages, you will find a listing of *Important Telephone Numbers* if you have questions about your coverage, need to ask about a claim, or need to have care pre-authorized. This booklet also provides you with the eligibility requirements to participate in the Plan benefits, procedures to follow if you are dissatisfied with the Trust Fund's decision on your Fee-for-Services medical, prescription drug or dental claim and all information required by the Employee Retirement Income Security Act (ERISA) of 1974. We urge you to read the entire booklet at least once. If you are married, share it with your spouse and keep it with your important papers so you can refer to it when needed.

All of us experience life events that impact our health and benefit coverage. The *Life Events* section of this booklet is designed to show you how your benefits work and how they fit into the different stages of your life. The SPD also describes when you and your Dependents become participants in the Plan, and details of each benefit program. There is also a section on how to file claims and appeal denial of claims. There is a *Glossary of Defined Terms* at the back of this SPD that contains definitions of many terms that are found in the ***SPD***.

Sincerely,

The Board of Trustees

Important Contact Information

The chart that follows shows the contact information for the various organizations that provide services under your Plan.

If You Have A Question Or Need Information About…	You Should Contact	Phone Number and web site
Fee For Service Medical Plan Information		
• Automated Eligibility & Benefits	Trust Fund Office	866-983-4353
• Benefit and Enrollment Questions	Trust Fund Office	800-527-4613 www.ironworkerbenny.com
• Provider Directories	Anthem Blue Cross of California	www.anthem.com/ca (or call the Trust Fund Office)
• Pre-Authorization and Utilization Review for Inpatient Hospitalizations (except for emergencies and childbirth)	Anthem Blue Cross of California	800-274-7767 www.anthem.com/ca
• Pre-Authorization and Utilization Review for Mental Health and Substance Abuse	Managed Health Network (MHN)	800-977-7962 www.MHN.com
• Pre-Authorization for Outpatient Surgeries, Procedures, and Various Other Services	Pacific Health Alliance (PHA)	855-754-7271 www.pacifichealthalliance.com
• Prescription Drug Benefit Questions	EnvisionRx Options	800-361-4542
• Prescription Drug Pre-Authorization Requests and Eligibility Questions	EnvisionRX Options	800-361-4542 www.envisionrx.com
• Reinforcing Smart Choices Program questions	Trust Fund Office	800-527-4613 www.ironworkerbenny.com
Medical HMO Plan Information Health Plan of Nevada		
o Enrollment	Trust Fund Office	800-527-4613
o Benefit Questions and Provider Information	Health Plan of Nevada	800-777-1840 www.healthplanofnevadacom
• *Kaiser Permanente (Northern or Southern CA)*		
o Enrollment	Trust Fund Office	800-527-4613
o Benefit Questions and Provider Information	Kaiser Permanente	800-464-4600 www.kp.org
Vision Plan Information • *Vision Service Plan*		
o Enrollment	Trust Fund Office	800-527-4613
o Benefit Questions and Provider Information	Vision Service Plan	800-877-7195 www.vsp.com
• *Spectera Vision Plan*		
o Enrollment	Trust Fund Office	800-527-4613
o Benefit Questions and Provider Information	Spectera Vision Plan	800-839-3242 www.spectera.com
Fee-For-Service Dental Plan Information *Delta Dental*		
o Enrollment	Trust Fund Office	800-527-4613
o Benefit Questions and Provider Information	Delta Dental	800-765-6003 www.deltadentalins.com

If You Have A Question Or Need Information About…	You Should Contact	Phone Number and web site
Dental HMO Plan Information		
• *Assurant Employee Benefits*		
o Enrollment	Trust Fund Office	800-527-4613
o Benefit Questions and Provider Information	Assurant Employee Benefits	800-443-2995 www.assurantemployeebenefits.com
• *DeltaCare, USA*		
o Enrollment	Trust Fund Office	800-527-4613
o Benefit Questions and Provider Information	Delta Dental, USA	800-422-4234 www.deltadentalins.com
• *Health Net Dental*		
o Enrollment	Trust Fund Office	800-527-4613
o Benefit Questions and Provider Information	Health Net	800-880-8113 www.healthnet.com
• *United Concordia*		
o Enrollment	Trust Fund Office	800-527-4613
o Benefit Questions and Provider Information	United Concordia	866-357-3304 www.unitedconcordia.com

Becoming a Plan Participant

Who Is Eligible

New Employee Eligibility

When you work for a Contributing Employer, that employer makes contributions to the Fund on your behalf based on the hours that you work. As a new Employee, you will become eligible for coverage effective on the first day of the second calendar month, following a period of not more than four consecutive calendar months (but at least three consecutive calendar months), in which you work at least 300 hours for one or more Contributing Employers. Your coverage will be effective on the first day of the fifth month, even if you meet the 300 hours requirement in your first one or two months of employment. For example, if you complete 300 hours during the consecutive calendar months of January through March, you would become eligible for coverage on May 1 (April would be a lag month to allow time for employer contributions).

Maintaining Your Eligibility

All hours worked for a Contributing Employer will be credited to an "Hour Bank" established for you, up to a maximum of 600 hours. Once you have qualified for initial coverage, you will continue to be covered for the period of time you have sufficient hours in your Hour Bank. The number of hours required for each month of coverage is 100 hours, and this amount will be subtracted from your Hour Bank each month to provide your coverage. You will remain eligible for coverage under the Plan if you have at least 100 hours in your Hour Bank.

Disability Extension

If you have an acute Illness or Injury that prevents you from working sufficient hours to maintain your eligibility, you must obtain a Certificate of Disability form from the Trust Fund Office. Complete your section of the form, have your doctor complete his/her section and return/mail it to the Trust Fund Office.

After the Fund has reviewed and approved any proof of disability, your Hour Bank will be frozen and you will be granted a limited extension of your eligibility beginning on the first day of the month following the date your disability started (provided you have not worked at least 100 hours in any month that is to be considered part of this extension). This extension will terminate the earlier of:

- The last day of the month you are no longer disabled; or
- The last day of the sixth month following the date the disability extension began.

When your Disability Extension has ended, your Hour Bank may provide you with additional coverage based on the number of hours in your Hour Bank at the time your extension became effective (subject to the Hour Bank maximum of 600 hours).

There will not be a disability extension granted for any month that you work for at least 100 hours.

This disability extension can provide you up to 6 months of additional eligibility if you remain disabled. All disabilities will be considered as one disability unless you reinstate your eligibility based on hours worked (by returning to work and working a minimum of 300 hours with a Contributing Employer before you will be eligible for a second disability extension).

Under no circumstances will the Fund allow more than 12 months of additional eligibility under this Disability Extension.

If you retire while on a disability extension, you receive the sum of the remainder of your disability extension and Hour Bank, up to a maximum of 12-months of extended coverage from the date of your retirement.

You will remain eligible for Active Employee benefits for the duration of the six-month extension, provided you are still disabled, and then you may use any hours in your Hour Bank. Once your Hour Bank expires, you will need to begin making the required monthly self-payments under COBRA or Retiree Self Pay benefits, if you applied for and qualified for Retiree Plan coverage at the time of your retirement.

Termination of Your Eligibility

Your eligibility will terminate on the earliest of:

- The last day of the calendar month in which you have fewer than 100 hours in your Hour Bank, after deduction of the current month's coverage;
- The date you last qualify for any special extensions of benefits described in in this SPD; or
- The date you enter full-time military service (Note: extended coverage may be elected under USSERA (see the Life Events section)).
- The date the Plan is discontinued; or
- The date of your death (your surviving spouse and covered Dependent Children would be able to use your existing Hour Bank to provide additional coverage under the Plan).

You will again become eligible if you have at least 300 hours credited to your Hour Bank during the 12-calendar month period following your termination of eligibility. All hours credited to your Hour Bank will be cancelled if your Hour Bank does not reach 300 hours within the 12 calendar-month period immediately following the termination of eligibility. In addition, all hours credited to your Hour Bank will be cancelled if:

- You work as an ironworker for any non-signatory (non-contributory) employer (non-Union work) or for cash payment;
- You knowingly allow a Contributing Employer to contribute to the Plan for less than all hours you have worked for the Employer for which contributions are required;
- You continue working for an Employer that has failed to contribute the required contributions to the Plan after you have been advised of the delinquent contributions;
- You are no longer a member in good standing of a Local Union in the District Council of Ironworkers of the State of California and Vicinity, and you are not registered on the “Out-of-Work” list during the period you are not eligible for benefits; or
- You fail to comply with the Plan’s subrogation provisions.

Dependent Eligibility

Your eligible Dependents will be eligible for medical, prescription drug, dental, life, and vision benefits when you become eligible for these benefits (if permitted by your specific plan of benefits). Your Dependents become eligible for coverage on the date you first become eligible. Coverage for a new Dependent starts on the date you acquire the Dependent provided you request and return a copy of the certified and recorded birth certificate and/or marriage certificate, along with an updated enrollment form showing your new Dependent to the Trust Fund Office within 31 days. Otherwise, your Dependent will be covered on the first of the month following receipt at the Trust Fund Office of your written notice of a new Dependent and all required documentation for that Dependent. Eligible Dependents will be covered

under the same medical (including prescription drugs), dental and vision programs you select.

Your eligible Dependents are defined as:

- Your spouse, which is the person to whom an Active Employee is legally married, as determined by applicable state law, until the marriage is ended by divorce or legal separation. A spouse who is also eligible as an Employee or Retiree will also be covered as your Dependent.

- Your same-sex Domestic Partner who:
  - Share a common residence;
  - Are not married to, or in a domestic partnership with, another adult;
  - Are not related by blood; and
  - Have filed a Declaration of Domestic Partnership with the California Secretary of State.

Please note: Coverage for a registered Domestic Partner (and eligible children of the Domestic Partner) is available <u>only to those enrolled in an HMO Plan</u>. Your Domestic Partner (and eligible children of the Domestic Partner) <u>are not</u> eligible for coverage under the Fee for Service Plan.

- Your Dependent child up to the end of the calendar month in which the child attains age 26. Dependent children covered up to age 26 include:
  - Your natural children (including children born out of wedlock if you, the Active Employee, are identified as the parent by birth certificate or appropriate judicial decree);
  - Legally adopted children and children placed with you for adoption; and
  - Stepchildren of the Active Employee (including covered children of a Domestic Partner).
  - A child for whom you, the Active Employee, have been named the legal guardian;
  - A child that the Plan is required to cover for benefits under a Qualified Medical Child Support Order (QMCSO). Notify the Trust Fund Office if you become aware of an order like this. Such an order could have an effect on your benefit coverage or elections. Refer to the *Glossary of Defined Terms* for the definition of a QMCSO. A free copy of the Plan's QMCSO procedures is available from the Trust Fund Office.

Eligibility may be continued past age 26 for an unmarried Dependent child (1) who is totally and permanently disabled and unable to engage in any substantial gainful activity due to any physical or mental disability. Proof of incapacity must be provided to the Fund Office on an annual basis or at the request of the Fund. The disabling condition must have been present before the child reaches the age of 26.

When both parents are covered as Employees under the Plan, any eligible children will be covered as Dependents of both parents.

Your Dependents' eligibility will terminate on the earliest of the following:

- The date your eligibility terminates;
- In the event of your death, the date your eligibility would have terminated based on the accumulated hours in your Hour Bank; or
- The date he or she no longer qualifies as an eligible Dependent; or
- The date the Plan is discontinued.

Enrolling For Benefits

When you become eligible for benefits, you will automatically be enrolled in the Ironworkers' Fee-For-Service medical plan and the self-funded dental and vision plans, as well as life, dependent life, and AD&D benefits. At the next Open Enrollment period, you will be given the opportunity to change your medical, dental and/or vision elections. The Trust Fund Office will send you a benefits information package in the month in which you initially become eligible. An enrollment form and designation of beneficiary documents will be included in the package. It is very important that you complete all of the forms and return them to the Trust Fund Office, otherwise, you may experience a delay in the processing of your benefits. All family members must be enrolled in the same plan options.

In order to establish Dependent coverage, you must provide the following to the Trust Fund Office:

- For your spouse's coverage, a certified copy of your certified and recorded marriage certificate (a copy of the temporary marriage certificate is only good for up to 6 months of eligibility from the date of marriage pending receipt of the certified document);
- For your natural children, a certified copy of their certified and recorded birth certificates (for newborns, a copy of the temporary hospital birth certificate is good for up to 6 months of eligibility from the child's date of birth pending receipt of the certified document);
- For your adopted children (or children placed for adoption), a certified copy of the adoption papers.
- For your stepchildren, a copy of the children's certified and recorded birth certificate or adoption papers.
- For a child for whom you are the legal guardian, a copy of the court order appointing you as the guardian.

On your enrollment form, you will need to list your Dependents with the Trust Fund Office and name a beneficiary for your death and AD&D benefits on the appropriate designation of beneficiary forms.

Choice of Plans

Depending on your state of residence and the terms of your Collective Bargaining Agreement (CBA), the Plan offers you choices between coverage under the Active Fee-For-Service Medical Plan or an HMO Medical Plan, and coverage under the Fee-For-Service Dental Plan or an HMO Dental Plan. Coverage under the plan options you select will continue as long as you remain eligible or until the next annual Open Enrollment period (or any subsequent special enrollment period), at which time you may elect to change your choice of medical and dental coverage. Benefit information will be mailed to you prior to the beginning of the Open Enrollment Period.

After you meet the eligibility requirements of the Fund, you (and any covered Dependents) will be eligible for the Active Plan coverage (unless your employer has elected to report less than the full hourly health and welfare contribution). Please contact the Trust Fund Office if you have questions regarding your plan of coverage.

Special Enrollment

If you decline enrollment for your spouse or Dependents because of other health insurance or group health plan coverage, you may be able to enroll them in the Plan if you or they lose eligibility for that other coverage (or if the employer stops contributing towards your or your spouse or Dependents' other coverage). However, you must submit enrollment documentation to the Trust Fund Office within 60 days after the other coverage ends (or after the employer stops contributing towards the other coverage).

If you move out of the service area of an HMO in which you are enrolled, you will automatically be placed in the FFS Plan. You may enroll in a another HMO plan option during the next annual Open Enrollment period.

In addition, if you have a new spouse as a result of marriage, or a new Dependent child as a result of birth, adoption, or placement for adoption, you may be able to enroll yourself and your spouse and Dependent children. Please see page 10 in the *Life Events* section of this booklet.

You and your spouse and Dependent children may also enroll in the Plan if you (or they) have coverage through Medicaid or a State Children's Health Insurance Program (SCHIP) and you (or they) lose eligibility for that coverage. However you must submit enrollment documentation to the Trust Fund Office within 60 days after the Medicaid or SCHIP coverage ends.

You and your spouse and Dependent children may also enroll in this Plan if you (or they) become eligible for a premium assistance program through Medicaid or SCHIP. However, you must submit enrollment documentation to the Trust Fund Office within 60 days after you (or they) are determined to be eligible for such assistance.

If you miss the prescribed 60-day window explained above, you may still enroll your spouse or Dependents, but their coverage will be effective on the first of the month following the date that the enrollment request plus any additional documentation required (such as birth or marriage certificates) are received at the Trust Fund Office.

To request special enrollment or obtain more information, contact the Trust Fund Office.

Designating Your Beneficiary for Life and AD&D Benefits

You may name more than one beneficiary and you may change your beneficiary at any time. If you name more than one beneficiary, you should indicate how your benefits should be divided. The initial designation or change of designation will take effect on the date it is received by the Plan. It's important that you name a beneficiary. If you don't name a beneficiary or if your beneficiary is not living at the time of your death, your life and/or AD&D benefits benefit will be paid to your survivors as follows:

- Spouse; or if none,
- Children, in equal shares; or if none,
- Parent(s), in equal shares; or if none,
- Brothers and sisters, in equal shares; or if none,
- Your estate.

Rescission of Benefits

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when premiums and contributions and self-payments are not timely paid in full, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan. Keeping an ineligible dependent enrolled under the Plan (for example, an ex-spouse, overage or ineligible dependent child, etc.) is considered fraud and you may be held liable for reimbursing the Trust Fund Office the full cost of all benefits provided for the ineligible Dependent.

Life Events

Your benefits are designed to adapt to your needs at different stages of your life. This section describes how your coverage is affected when different events occur.

Any reference to your spouse below also includes your Domestic Partner.

Note: You should refer to the Schedule of Medical Benefits for your specific plan option, as not all benefits may be available to Active participants and/or their Dependents.

Life Events That May Affect Your Eligibility for Coverage

- Marriage
- Birth of a child
- Adoption of a child or placement of a child for adoption
- Divorce or Legal Separation
- Child reaches maximum age
- Stopping work
- Disability
- Death of a Dependent
- Military duty
- Retirement
- Your death

Getting Married

When you marry, your medical, prescription drug, vision, dental, life, and dependent life benefits will cover your spouse. To enroll your spouse for coverage, call the Trust Fund Office and request an enrollment form and complete and return the form along with a copy of the non-certified certificate of marriage within 31 days to the Trust Fund Office in order for your spouse's coverage to begin on the date of marriage. This temporary marriage certificate is only good for up to 6 months of eligibility from the date of marriage. A copy of your **certified and recorded marriage certificate from the Hall of Records from the county in which the marriage was performed** must be provided to the Trust Fund Office within six (6) months of the date of marriage for coverage to continue.

Failure to enroll your spouse within 31 days from the date of marriage could result in a delay of coverage until the first day of the month following receipt by the Trust Fund Office of the required documentation.

Your step-children will be covered if they meet the eligibility requirements for a Dependent child (refer to page 6) retroactive to the date of your marriage, as the Active Employee, to the natural or adoptive parent of a child.

You will also need to decide whether to name your spouse as your beneficiary for Life and AD&D benefits.

If You Have A Baby or Adopt A Child

Your natural child will be eligible for coverage on the date of birth, provided you complete and return the enrollment form within 31 days from the date of birth. A copy of the hospital certificate will be accepted for temporary coverage only for a period up to six months from the date of birth. A copy of the **certified and recorded birth certificate from the Hall of Records from the county in which the child was born** must be received by the Trust Fund Office within six (6) months of the date of birth for coverage to continue.

Failure to enroll your child within 31 days from the date of birth could result in a delay of coverage until the first day of the month following receipt by the Trust Fund Office of the required documentation.

If a child is placed with you for adoption, he or she will be eligible for coverage on the date of placement if you provide the Trust Fund office with a copy of the certified adoption papers. See the *Becoming a Plan Participant* section for the requirements for adopted children and stepchildren.

If You Become Legally Separated or Divorced

If you and your spouse become legally separated or divorced, your spouse will no longer be eligible for coverage. However, your spouse may elect to continue coverage under COBRA for up to 36 months. You or your former spouse must notify the Trust Fund Office within 60 days after the divorce or legal separation in order for your spouse to obtain COBRA continuation coverage.

A Qualified Medical Child Support Order (QMCSO) could have an effect on your benefit coverage or elections. Please notify the Trust Fund Office if you become aware of an order like this as part of divorce proceedings.

Should you become legally separated or divorced, please review your beneficiary designations for Life and AD&D benefits and decide whether you need to name a different beneficiary.

If Your Child Loses His or Her Eligibility

In general, your child is no longer eligible for coverage after the last day of the calendar month in which he or she attains age 26.

Your child may elect to continue coverage under COBRA for up to 36 months. You or your child must notify the Trust Fund Office within 60 days after your child no longer meets the Fund's eligibility requirements to obtain COBRA continuation coverage.

If your child is not capable of self-supporting employment because of a physical or mental disability, you may be allowed to continue coverage for that child for as long as your own coverage continues. To qualify, your child's disability must begin before the child attains age 26.

If Your Spouse or Child Dies

Notify the Trust Fund Office as soon as possible after the death of a Dependent to change the Dependent listing and file a claim for Dependent death benefits. See the *Claims for Benefits* section for more information on how to file a death benefit claim.

You will also want to review your beneficiary designation and determine whether any changes are necessary.

If You Become Disabled

If you become disabled (unable to work in the trade), you must obtain a Certificate of Disability from the Trust Fund Office. Have the certificate completed by your Physician and return it to the Trust Fund Office for processing. If you are undergoing inpatient or residential substance abuse treatment authorized by Managed Health Network (MHN) you must submit proof of such treatment to the Trust Fund Office for processing.

After satisfactory proof of your disability has been received, your Hour Bank will be frozen and you will be granted a limited extension of eligibility beginning on the first month following the date the disability commenced.

Benefits During Disability

If you are disabled:

- Your medical benefits can be extended if your Physician certifies your disability.
- Check with the Trust Fund Office for eligibility.

Your disability extension will end on the earlier of:

- The last day of the month in which you are no longer disabled; or
- The last day of the sixth month following the date the disability extension began.

If you retire while on a disability extension, you could receive Active benefits for up to a maximum of six months, depending on your Physician's statement, plus any months for which your Hour Bank will provide coverage.

If You Stop Working For A Contributing Employer

Coverage for you and your Dependents will end on the last day of the month in which you cease being eligible because your Hour Bank has too few hours left to provide eligibility for the next month's coverage. Coverage will also be terminated the last day of the month in which you perform work for any non-contributing employer.

If You Take A Family or Medical Leave Of Absence (FMLA)

The Family and Medical Leave Act (FMLA) allows you to take up to 12 weeks of unpaid leave during any 12-month period due to:

- The birth of a child or placement of a child with you for adoption;
- The care of a seriously ill spouse, parent, or child (note that if the illness or injury was incurred in the line of duty while on active duty in the Armed Forces, you may take up to 26 weeks of leave); or
- To attend to a "qualifying exigency" arising out of the fact that your spouse, son, daughter or parent is on active duty or has been notified of an impending call up to active duty in the Armed Forces; or
- Your own serious illness.

You and your Employer must meet certain requirements in order for you to be eligible for this unpaid leave. Please contact your Employer for more information about your eligibility for Family and Medical Leave benefits. The Plan will maintain your prior eligible status until the end of the leave, provided your Employer properly grants the leave in compliance with federal law and makes the required notification and payment to the Trust Fund Office. The Trust Fund does not make any determinations regarding eligibility for FMLA leave.

If You Are Called Into Military Service

If you are called into military service (active duty or inactive duty training) for up to 30 days, your health care coverage will continue. If you are called into military service for 31 or more days, you may continue coverage for yourself and your Dependents by making self-contributions for up to 24 months under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

It is your responsibility to notify the Trust Fund Office if you are called into military service (active duty or inactive duty training).

Your coverage will continue to the earliest of the following:

- The date you or your Dependents do not make the required self-contributions within 30 days of the due date;
- The date the Plan no longer provides any group health benefits;
- The date you reinstate your eligibility for coverage under the Plan;
- The end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or
- The last day of the month after 24 consecutive months.

Once the Fund receives notice that the employee has been called to active duty, it will offer the right to elect USERRA coverage for the employee (and any eligible dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the employee does not elect USERRA for the dependents, those dependents cannot elect USERRA separately. Additionally, the employee (and any eligible dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA therefore either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively.

Generally, the rules governing your right to continue coverage (e.g., notice requirements, election period, timeliness of payments) are the same as the COBRA requirements. For more information about self-contributions under USERRA, contact the Trust Fund Office.

If You Do Not Continue Coverage Under USERRA

Your coverage will end immediately when you enter active military service. Your Dependents will have the opportunity to elect COBRA continuation.

Coverage After Your Discharge

When you are discharged or released from military service, you have 90 days to return to work for a Contributing Employer. If your Employer reports your return to the Trust Fund Office during this 90-day period, your eligibility and your Dependents' eligibility will be reinstated on the day you return to work. However, if you are disabled at the time of discharge and your disability was incurred during your military service, under USERRA you may be allowed more than 90 days to return to work for a Contributing Employer.

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

Reemployment: Following your discharge from service, you may be eligible to apply for reemployment with your former employer in accord with USERRA. Such reemployment includes your right to elect reinstatement in any existing health care coverage provided by your employer.

If You Retire From Active Employment

When you retire, you may be eligible for retiree coverage under a separate Plan. Please see the ***SPD for the California Ironworkers Field For Non-Medicare Retired Employees And Their Eligible Dependents*** (the "Retiree Plan") for information about retiree benefits.

Retirees may be eligible for medical/prescription drug and, if elected at the time of retirement, dental, life insurance and vision benefits. You must make self-contributions for retiree coverage.

In The Event of Your Death

If you die, your beneficiary will receive your life benefit. He or she may also receive an accidental death and dismemberment (AD&D) benefit if your death is caused by an accident. See the *Life, Dependent Life, and Accidental Death and Dismemberment Benefits* section for more information about these benefits.

If you die while you are eligible for coverage (including during any Disability Extension), your surviving Spouse and covered Dependents may use any existing Hour Bank to extend their coverage under the plan (without charge). Following this period, coverage for your surviving Dependents will continue for a six month extension of benefits at no cost. After the extension has ended, your spouse and Dependents will be offered COBRA continuation coverage. If he or she elects to continue benefit coverage under COBRA continuation, he or she waives all rights to continue coverage under the surviving Dependent benefit. As an alternative, they could elect Retiree Coverage if the following requirements are met at the time of your

death:

- You are not on a disability extension at the time of your death;
- You have earned at least 15 pension credits. For purposes of determining eligibility for this provision, a pension credit is defined as 1,400 hours in the California Ironworkers Field Pension Trust;
- You and your spouse were married for at least 12 months prior to your death; and
- The cause of your death was not the result of any intentional action taken by your spouse.

Extended benefits do not include dependent life benefits. Your Dependents must remain enrolled in the same medical plan you were enrolled in at the time of your death.

Surviving Dependent coverage will terminate on the earliest of:

- The date self-payment contributions are not received by the Trust Fund Office (payment is due by the 15th day of the month prior to the month of coverage); or
- The date your surviving spouse remarries; or
- Your Dependents no longer qualify as a Dependent; or
- The date this provision is terminated by the Board of Trustees.

When Coverage Terminates

COBRA Continuation Coverage

Under the Consolidated Omnibus Budget Reconciliation Act of 1985, or COBRA, you and your Dependents may continue health care coverage past the date coverage would otherwise end if your loss of health coverage is due to a qualifying event (described below). If you and/or your Dependents lose coverage due to a qualifying event and you make self-contributions, you and/or your Dependents may continue:

- Medical and prescription drug benefits, or
- Medical, prescription drug, dental, and vision benefits.

The continuation coverage that you and/or your Dependents elect will be identical to the Plan coverage you had while actively covered under the Plan. You will *not* be eligible to continue coverage for life, dependent life, and AD&D benefits.

NOTE: Domestic Partners and children of Domestic Partners are offered the ability to elect "COBRA-like" temporary continuation of benefits when coverage ends; however, Domestic Partners and children of Domestic Partners are not considered Qualified Beneficiaries and therefore may not have all the federally protected rights afforded to a Qualified Beneficiary.

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

Alternatives to COBRA

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

If you have a newborn child, adopt a child, or have a child placed with you for adoption while your COBRA continuation coverage is in effect, you may add such child to your coverage. You must notify the Trust Fund Office, in writing, of the birth, adoption, or placement of a child with you for adoption, in order to have this child added to your coverage.

Children born, adopted, or placed for adoption, as described above, have the same COBRA rights as a spouse or Dependents who were covered by the Plan before the event that triggered COBRA continuation coverage. Like all qualified beneficiaries with COBRA continuation coverage, the child's continued coverage depends on timely and uninterrupted self-contributions on their behalf.

Qualifying Events

COBRA continuation coverage is offered to you if you and/or your Dependents lose coverage as a result of a qualifying event. Please note that the COBRA period begins on the date that coverage is lost (rather than the date of the Qualifying event). Qualifying events include:

- Termination of your employment (for causes other than gross misconduct);

- Reduction in your hours;
- Your death;
- You and your spouse are legally separated or divorced; and
- Your child loses Dependent status under the Plan.

Notifying the Trust Fund Office and the COBRA Election Period

You or your Dependent must inform the Trust Fund Office of a legal separation, divorce, or a child losing Dependent status under the Plan within 60 days of the qualifying event. If you do not notify the Trust Fund Office Eligibility Department within 60 days of such an event, you will lose your right to elect COBRA continuation coverage.

Your Employer will notify the Trust Fund Office of your termination of employment, reduction in hours, or death. However, because Employers contributing to the Plan may not be aware of these events, the Trust Fund Office will rely on its records for determining when eligibility is lost under these circumstances. To help ensure that you do not suffer a gap in coverage, we urge you or your family to notify the Trust Fund Office of qualifying events as soon as they occur.

When the Trust Fund Office is notified that you and/or your Dependents has lost health coverage due to one of these events, you and your Dependents will be notified of the right to elect COBRA continuation coverage. Once you receive a COBRA notice from the Trust Fund Office, you have 60 days from the date of that notice in which to elect COBRA continuation coverage. If you do not elect coverage, your Dependents will be given the opportunity to elect coverage independently from you.

How to Provide Notice to the Trust Fund Office

Notice must be provided in writing. Send a letter to the Trust Fund Office containing the following information:

- Your name and Social Security Number,
- The name of the Fund (California Ironworkers Field Welfare Plan for Active Employees and their Eligible Dependents),
- The qualifying event you are providing notice for,
- The date of the qualifying event, and
- The individual(s) affected by the qualifying event and their relationship to you.

If the qualifying event is your divorce or legal separation from your spouse, you must provide a copy of the divorce decree or legal separation documents as soon as it becomes available.

Paying For COBRA Continuation Coverage

The Trust Fund Office will notify you of the cost of your COBRA continuation coverage when it notifies you of your right to coverage. The cost for COBRA coverage will be determined by the Trustees on a yearly basis, and will not exceed 102% of the cost to provide this coverage for similarly situated Active Employees and Dependents. The cost for extended disability coverage (from the 19th month through the 29th month) is an amount determined by the Trustees, not to exceed 150% of the cost to provide coverage.

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

Subsequent payments are due on the first business day of each month for which coverage is provided, with a grace period of 30 days. However, in order to consistently maintain your eligibility on the Trust Fund records, it is recommended that you make payment by the 20th of the month prior to the coverage month. No claims will be paid or eligibility reported to a pre-paid plan for any month until payment is received (coverage is suspended).

If payment is not received by the end of the grace period, all benefits will terminate immediately. Once your COBRA continuation coverage is terminated, it cannot be reinstated.

Supplemental Retiree Welfare Benefit. The California Ironworkers Field Welfare Plan has established a Supplemental Retiree Benefit (SRB) account for each Active Employee. The SRB account may only be used by the Active Employee to pay for the active employee's COBRA premiums (including the COBRA premiums of his eligible Dependents as defined in section 152 of the Code). Active Employees may use the SRB for COBRA premiums only.

If an active employee dies with a balance in his or her SRB, the balance shall be payable to the active employee's beneficiary or estate in the calendar year after the active employee's death. These payments will be taxable income (but not taxable wages).

Period of Coverage

Coverage Continues for 18 Months: You may elect to purchase continued coverage for yourself and your Dependents for up to 18 months if coverage ends due to your termination of employment (other than for gross misconduct) or your reduction in hours.

Coverage Continues for 29 Months: If your employment ends due to your termination of employment (other than for gross misconduct) or reduction in hours, and at that time, or within 60 days of the event, you or one of your Dependents is totally disabled (as determined by Social Security), coverage may continue for an additional 11 months, for a total of 29 months. To continue coverage for an additional 11 months, you must notify the Trust Fund Office of your "Determination of Disability" by the Social Security Administration within 60 days of the date of the determination and before the end of the initial 18-month period of COBRA continuation coverage.

Coverage Continues for 36 Months: Your Dependents may elect to continue coverage for up to 36 months if coverage ends because of your:

- Death;
- Legal separation or divorce; or
- Dependent child no longer qualifying for Dependent coverage under the Plan.

Early Termination of Continued Coverage

The period of COBRA continuation coverage for you and/or your Dependents may be cut short for any of the following reasons:

- You or your Dependents do not make the required self-contributions within 30 days of the due date;
- The Plan ceases to provide any group health benefits;
- You or your Dependents become covered under any other group health care plan;
- You or your eligible spouse becomes entitled to (eligible for and enrolled in) Medicare after electing COBRA continuation coverage; or

- You or your Dependents, during an extension of the maximum COBRA period of coverage to 29-months due to disability, are no longer determined to be disabled by the Social Security Administration.

Effect of Medicare Entitlement Before a Termination of Employment or Reduction in Hours

If your loss of coverage because of reduced hours, termination of employment, or retirement occurs less than 18 months after the date you become entitled to Medicare (Part A, Part B, or both), the ending date for the maximum period of COBRA continuation coverage for your Dependents covered under the Trust Fund will be 36 months from the date of your Medicare entitlement, but not less than 18 months.

Choosing Not to Elect COBRA

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

In considering whether to elect COBRA continuation coverage, you should take into account that a failure to continue your group health coverage will affect your future rights under Federal law. You have the right to request Special Enrollment in another group health plan for which you are otherwise eligible (such as a plan sponsored by your spouse's employer). Special Enrollment under this provision is generally allowed within 30 days after your group health coverage ends because of the qualifying events listed above or at the end of COBRA continuation coverage if you get COBRA continuation coverage for the maximum time available to you.

Open Enrollment Under COBRA Continuation Coverage

COBRA participants may enroll for coverage under the medical option of their choice, provided they are eligible for coverage during the Open Enrollment Period.

Post-COBRA Coverage Under an HMO – California COBRA Law

If you are a COBRA participant enrolled in HMO medical coverage, California law has a provision that impacts the length of time you may continue coverage. This law applies only to your HMO medical coverage and not to the other health care benefits usually available under COBRA.

- If your Qualifying Event was termination of your employment or reporting of less than the minimum required work hours for a month and you exhaust the 18 months of coverage normally available after such a Qualifying Event (or the 29 months available in the case of disability), you may continue your HMO medical coverage for an additional 18 months (or an additional 7 months in the case of a disability).
- To take advantage of this provision, you must remain in the HMO plan.

All arrangements for additional months of coverage under the California COBRA law must be made directly with the HMO. The Fund is not involved.

Medical Benefits

Choice of Medical Plans

You may choose coverage under the Fee-For-Service medical plan (described in this section of the SPD) or an HMO plan. The Fee-For-Service medical plan is provided through a Preferred Provider Organization (PPO) network of providers. The contact information for the PPO network is on the "Important Contact Information" chart at the beginning of this SPD.

- If you and your eligible Dependents **live in California**, your Contract Provider network is the Anthem Blue Cross Prudent Buyer network.
- If you **live outside of California, or if you are travelling outside of California**, your Contract Provider network is provided through the National BlueCard network.

You must live or work within the service area of an HMO in order to enroll in that HMO. Please refer to the Schedule of Medical Benefits for a list of the HMO options available in your state. Benefits and exclusions and limitations for the HMO plans are not described in this booklet. HMO benefits are described in the *Evidence of Coverage* booklets for each HMO.

After you meet the eligibility requirements of the Fund, you (and any covered Dependents) will be eligible for the Active Plan coverage (unless your employer has elected to report less than the full hourly health and welfare contribution). Please contact the Trust Fund Office if you have questions regarding your plan of coverage.

Your Responsibility

It is important to remember that the Fee-For-Service Medical Plan is not designed to cover every health care expense. The Plan pays for Allowed Charges up to the limits and under the conditions established by the Plan. The decisions about how and when you receive medical care are up to you and your Physician—not the Plan. The Plan determines how much it will pay; you and your Physician must decide what medical care is best for you.

How the Fee-For-Service Medical Plan Works

The Fee-For-Service Medical Plan pays benefits to cover some of the costs for a wide range of services and supplies, including Physician charges, diagnostic testing, hospital charges, and surgery. This section describes how payment of Allowed Charges are shared between you and the Plan and which services are covered.

Calendar Year Deductible

The Plan deductible is a dollar amount you must pay before the Plan will start paying any benefits in a calendar year. The deductible is higher if you use a Non-Contract Provider than when you use a Contract Provider through the contracted PPO network. There is also a maximum amount each family needs to pay toward the deductible each calendar year before the deductible is waived for all family members for the remainder to that calendar year. The individual and family calendar year deductibles are shown in the Schedule of Medical Benefits:

Any Allowed Charges that are accumulated to your Deductible in the last quarter of the calendar year will be used to also satisfy your Deductible in the following calendar year.

Coinsurance and Copays

Generally, the Plan pays a percentage of the Contract Rate for services of PPO Contract Providers and a lower percentage of Allowable Charges for services of Non-Contract Providers. This percentage is called Coinsurance. You must pay the remaining amount of Allowed Charges, unless you have incurred Allowed Charges in excess of the Annual Out-of-Pocket Maximum (see below).

For some services from Contract Providers, you simply pay a flat dollar Copay at the time you receive services and the Plan pays the balance of the Contract Rate. For other services, you may be responsible for a flat dollar copay and a percentage of coinsurance. See the Schedule of Medical Benefits for more information.

You must pay any remaining charges not covered by the Plan, such as for non-covered services or charges that exceed the Plan's Allowable Charge from Non-Contract Providers.

If you need to see a Physician:

- Call to make an appointment.
- Write down any questions you may have before your appointment. This way, you will not forget to ask your Physician important questions during your appointment.
- Make a list of any medications you're taking. Be sure to note how often you take the medications.
- Show your ID card when you go to your appointment.
- If the Physician's office does not file the claim for you, file a claim form with the Trust Fund Office. It's a good idea to make a copy of the claim form and any supporting materials for your records before submitting the claim.

Annual Out-Of-Pocket Maximum

Once your coinsurance payments and copays for Allowed Charges for each family member reach the amount shown in the Schedule of Medical Benefits under Annual Out-of-Pocket Maximum the Plan pays 100% of remaining Allowed Charges for the rest of that calendar year for that individual. Note that the Out-of-Pocket Maximum is unlimited for services of Non-Contract Providers. You must satisfy the calendar year deductible before the plan begins to pay coinsurance. **The following expenses do not accumulate to your Out-of-Pocket maximum:**

- Calendar year Deductible;
- Amounts you pay for a skilled nursing facility;
- Non covered expenses;
- Vision and dental care (including orthodontics);
- Balance billed amounts;
- Services from a Non-contract provider; and
- Charges in excess of benefit maximums (including amounts of the MAC for certain procedures).

Please note: Any Deductible or Out-of-Pocket amounts accumulated while you are not enrolled in the wellness program do **NOT** carry over if you decide to participate in the wellness program.

The family out-of-pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than their individual Out-of-Pocket amount.

Please note: You have a separate Out-of-Pocket limit for:

- ***In-Network prescription drugs:*** A separate Out-of-Pocket limits the amount that you are responsible for in a calendar year for In-Network prescription drugs. Please see the Schedule of Medical Benefits for a complete explanation.
- ***Each Emergency Room visit in a Non-Contract Hospital for an Emergency Medical Condition***. If you are treated for an Emergency Medical Condition in a Non-Contract Hospital, the maximum

coinsurance that you will be responsible for is $6,000. However, you may be responsible for any charges over the Allowed Charge. If it is determined that you do not have an Emergency Medical Condition, payment will be reduced to the Non-Contracted coinsurance and the coinsurance limit will not apply.

Maximum Allowable Charge

The facility charges associated with certain services will be subject to a ***Maximum Allowable Charge (MAC)***. The MAC is the most that the Plan will pay for a limit on the amount that the Plan will pay for the facility and certain other charges for:

Inpatient Hospital (for California Residents Only):

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

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

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

Please note:

- The MAC **does not apply** to the above outpatient procedures if they are performed at a licensed ambulatory surgical center.
- The MAC does not apply to charges from medical providers including, but not limited to, surgeons, assistant surgeons, anesthesiologists, etc.
- The MAC for Total Hip and Total Knee replacements only apply **in the state of California.**

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

Inpatient Hospital Procedures

The MAC ***only*** applies to inpatient hospital surgeries for **total hip replacement and total knee replacement**, as well as for the prostheses required for the surgeries. Both surgeries must be pre-authorized by Anthem Blue Cross in order to avoid an additional 10% coinsurance payment. Please see page 24 for more information about how to contact and pre-authorize with Anthem Blue Cross.

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

For a hip or knee replacement, the Plan will apply benefits to the lesser of the MAC or the Contract Rate if the surgeries are performed in-network at either a Value Based Site or at a Contract Provider hospital that is not a Value Based Site.

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

Value Based Sites are only applicable for inpatient total hip replacement or total knee replacement surgeries. The MAC for total hip replacement and total knee replacement surgeries can be found in the Schedule of Medical Benefits.

Outpatient Hospital vs. Ambulatory Surgical Center

The MAC *only* applies to outpatient arthroscopy, cataract surgery, and colonoscopies performed in the outpatient department of a Hospital. If you have your colonoscopy, arthroscopy or cataract surgery at a free-standing ambulatory surgery center, normal Plan benefits apply (as outlined in the Schedule of Benefits).

All of these surgeries or procedures must be pre-authorized by Pacific Health Alliance (PHA) in order to avoid an additional 10% coinsurance payment. Please see page 26 for more information about how to contact and pre-authorize services with PHA.

- For arthroscopies, cataract surgeries, and colonoscopies **performed in the outpatient department of a Contracted Hospital**, the Plan **will allow the lesser of the MAC or the Contracted Rate (after Deductible)**.
- For arthroscopies, cataract surgeries, and colonoscopies **performed at a Contracted free-standing ambulatory surgical center,** the Plan **will allow normal plan benefits (not subject to the MAC).**
- For arthroscopies, cataract surgeries, and colonoscopies **performed at the outpatient department of a Non-Contracted Hospital or Non-Contracted surgery center**, you are responsible for any amount over the $350 maximum (after Deductible).

The MAC for arthroscopy, cataract surgery, and colonoscopies **performed at the outpatient department of a Contracted Hospital** can be found in the Schedule of Medical Benefits.

Exceptions Process

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

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

Information About MAC

Upon request, Anthem will provide you with:

- A list of providers, hospitals, and outpatient surgery centers that accept the MAC for a particular inpatient or outpatient service;
- A list or providers, hospitals, and outpatient surgery centers that will accept a negotiated price above the MAC; and

- Information on the process and underlying data used to ensure that an adequate number of providers, hospitals, and outpatient surgery centers that accept the MAC meet reasonable quality standards.

Allowed Charges/Allowable Charges

The Plan pays for services of Non-Contract Providers only to the extent that they are Allowed Charges under the Plan. This amount may be less than the billed charges. You are always responsible for any charges that exceed the Plan's Allowable Charges. Refer to the *Glossary of Defined Terms* for a more complete definition.

What Is Medically Necessary?

The Plan pays benefits only for services and supplies that are Medically Necessary (except for covered preventive care services). In general, "Medically Necessary" means they are:

- Necessary to treat the illness or injury;
- Ordered by a Physician;
- Appropriate for the patient's circumstances;
- Consistent with the diagnosis; and
- Not Experimental or Investigational.

You will find a complete definition in the ***Glossary of Defined Terms***.

Maximizing Your Medical Benefits

The Plan has three cost management programs designed to help manage certain health care costs:

- A Contracted Provider network;
- A pre-authorization and utilization review (UR) program; and
- MAC amounts for certain surgical procedures in California.

Contract Provider Network

The Board of Trustees has contracted with organizations that provide Contract Provider networks. Physicians, hospitals and other health care providers participating in the Contract Provider networks have agreed to negotiated fees and to meet the organizations' standards. The names of these organizations and contact information are listed under the *Important Telephone Numbers* in the front of this SPD.

When you use Contract Providers, you save money for yourself and the Plan because these providers have agreed to charge a reduced amount for their services. For a free Directory of network Contract Providers available to you, please go to www.anthem.com. For most covered services, your coinsurance obligation will be lower if you use a Contracted Provider, as shown in the Schedule of Medical Benefits.

Contract Provider Network

A network of Physicians and hospitals that have agreed to charge Contract Rates. Since Contract Providers have agreed to these Contract Rates, you help control health care costs for you and the Plan when you use Contract Providers.

Special Reimbursement Provisions

In the situations listed below, the Plan will reimburse you at the Contract Provider Coinsurance percentage for charges incurred for services of Non-Contract Providers:

SPECIAL REIMBURSEMENT PROVISIONS if the services of certain Non-Contract Providers are used.	**WHAT THE PLAN PAYS (toward eligible claims submitted by an Non-Contract provider)**
• The medical plan does not have a Contract provider qualified or available to provide the preventive services required by Health Reform so the participant must use the services of a Non-Contract provider. • If a Non-Contracted anesthesiologist is used when surgery is performed by a surgeon who is a Contracted Provider and the services are provided at a Contracted facility. • If a Non-Contracted assistant surgeon is used when the covered surgery is performed by a surgeon who is a Contracted Provider, and he or she is providing services at a Contract Provider facility. • If you receive emergency room treatment from a Non-Contract emergency room Physician at a Contracted facility. • A Contract Provider Physician refers you for an initial consultation to a Non-Contract Provider Specialist. • If you receive diagnostic testing (laboratory or radiology services) at a Contract Provider facility that is ordered by a Contract Provider Physician, but the professional services to interpret the test results are performed by a Non-Contract Provider.	As if the care was provided by a Contract Provider (including deductible, coinsurance and copays) and the allowance for bills will be reimbursed according to the Allowed Charge for Non-Contract providers.
If you live outside of the service area of a Contract Provider (more than 30 miles) for the type of medical treatment you require.	The Plan will pay 80% of the Allowable Charges subject to the out of network deductible.
If services could have been performed by a Contracted Provider, but it was your choice to receive services from a Non-Contracted Provider, the Plan will reimburse you at the Non-Contracted level of benefits. For example, if you receive services from a Non-Contract Provider who is more distant from your home than a Contract Provider who could have provided the services, the Plan will reimburse you at the Non-Contract Provider level of benefits.	As if the care was provided Non-Contract (including deductible, coinsurance, copays and Out-of-Pocket Limit.)

Pre-authorization and Utilization Review

The Board of Trustees has contracted with several organizations that provide pre-authorization and utilization review (UR) services. These services help ensure that you receive quality care in a way that uses the Plan's valuable health care resources as wisely as possible. To make it work, you need to become involved in the decisions regarding your care. The names and contact information of the companies that provide pre-authorization and utilization review is shown under the Important Telephone Numbers in the front of this SPD.

Pre-authorization requires you to obtain prior approval of certain services before you receive them, but each has differences based on the type of service, as described below:

Pre-Authorization of Inpatient Hospitalizations

You must obtain pre-authorization for any inpatient hospitalizations and services with Anthem Blue Cross (except in the case of an emergency or for childbirth) before you are admitted.

Pre-Authorization of Inpatient Mental Health/Substance Abuse Services

You must obtain pre-authorization for inpatient mental health and substance abuse admissions (except for emergency hospitalizations) and services with Managed Health Network (MHN) before you are admitted.

Pre-Authorization of Outpatient Surgeries and Procedures

You must obtain pre-authorization from Pacific Health Alliance (PHA) for:

1. outpatient surgeries and procedures (including arthroscopies, cataract surgery, and colonoscopies);
2. diagnostic tests including but not limited to MRI, PET, bone scans and CT scans;
3. physical therapy visits;
4. durable medical equipment costing in excess of $500;
5. chemotherapy or radiation therapy; and
6. genetic testing.

Note: *if any of these services are performed in the Physician's office during the course of any regular office visit (e.g., EKG, x-rays, ultrasounds, etc.), no pre-authorization is required, including during a physical exam. However, if you are sent to a free-standing facility for any diagnostic tests (e.g., MRI, PET, CT, bone scans), a pre-authorization will be required.*

Pre-Authorization or Non-Formulary Brand or Generic Drugs

You must obtain pre-authorization for non-formulary brand name or generic drugs with EnvisionRx.

Pre-authorization are required whether you receive a medical service or supply from a Contract Provider or from a Non-Contract Provider.

Exception for Childbirth. Under federal law, the Plan may not restrict benefits for a mother's or newborn child's hospital stay in connection with childbirth to less than 48 hours following a vaginal delivery or 96 hours following a cesarean section. In addition, the Plan may not require a provider to obtain authorization for prescribing a length of stay not in excess of 48 hours (or 96 hours). However, the law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). Except for childbirth, if your Physician recommends a hospitalization, you or your Physician must call for pre-authorization of your hospital stay. If your admission is pre-certified, the Plan pays its normal level of benefits. If not, the Plan will reduce its benefit payment.

Important: Failure to obtain pre-authorization for medical services and supplies when required will result in the Plan's coinsurance payment percentage being reduced by 10% and you will become responsible for an additional 10% of coinsurance. For prescription drugs, failure to obtain pre-authorization means that the non-formulary brand name or generic drug will not be covered by the Plan. **Please note: this 10% penalty will not accumulate to your annual out-of-pocket maximum.**

See the Schedule of Medical Benefits beginning on page 28 (and the Important Telephone Numbers at the front of this booklet) for the contact information for Anthem Blue Cross, MHN, PHA, and EnvisionRx.

When you or your Physician calls Anthem Blue Cross or MHN (as applicable) before an inpatient hospital admission, the Anthem Blue Cross or MHN representative will evaluate whether a hospital admission is needed and determine the expected length of stay. In the case of an emergency admission, Anthem Blue Cross or MHN must be notified the next working day after admission.

PHA will offer you assistance in finding the lowest cost, quality options for receiving any outpatient treatment, procedure, surgery, or test outside of your regular Physician's office. In addition, PHA will help identify the names of potential primary care Physicians if you do not already have one, as well provide you with a 24-hour, seven-day-a-week Nurse Line staffed by registered nurses who can answer your questions about health issues.

Utilization Review While You Are Hospitalized

Once you are admitted to a hospital, the utilization review program monitors your hospital stay. If additional days are required because of complications or other medical reasons, your stay will be certified for the appropriate number of additional days of inpatient care.

If you receive emergency hospitalization, you or a family member must call for utilization review on the next working day following your admission to the hospital.

Provider Non-Discrimination

The Plan will provide benefits for covered services without regard to the type of health care provider, as long as that individual is licensed to perform the covered services, and is performing services within the scope of that license, as defined and regulated under the laws of the State in which the provider is practicing.

Reinforcing Smart Choices Program

The Reinforcing Smart Choices Program (the "Wellness Program") is a program designed to bring high quality care to you and your covered spouse, and at the same time, make health care more affordable for everyone.

- ***If you and your spouse do not participate in the Wellness Program***, you will be responsible for higher coinsurance and copays for Physician office visits, prescription drugs, and certain other services.

- ***If you and your spouse do participate in the Reinforcing Smart Choices Wellness Program,*** you will be responsible for less out-of-pocket coinsurance and copays for certain services.

The Reinforcing Smart Choices Program offers you a way to take certain actions to learn about and improve your health, and in return, receive certain rewards. If you and your spouse do not meet all of the requirements of the Program's "promise commitment", you will not be eligible to receive the rewards of the program.

The Promise Commitment

When you and your spouse make a "promise commitment" to the Reinforcing Smart Choices Program, you commit to take certain actions to learn about and improve your health. When you do, you become eligible to receive lower coinsurance and/or copays for certain Contract Provider services. If your spouse is covered by this Plan, he or she must also make and complete the Program's promise commitment.

The promise commitment requires that **both you and your spouse must each**:

1. Keep your contact information up to date with the Trust Fund Office;
2. Provide a cell phone number (if available) and agree to let the Trust Fund Office contact you with general information about the Reinforcing Smart Choices Program and other Plan programs. At this time, the Fund is only doing paper mailings. However, you may receive text messages at a future

time; and

3. Complete a biometric health screening by the date designated by the Trust Fund Office.

If you and your spouse fulfill the promise commitment described above, you, your spouse, and any eligible Dependent children will be eligible to receive the rewards of the Reinforcing Smart Choices program. If you and your spouse do not fulfill the promise commitment described above, you, your spouse and any eligible Dependent children will NOT be eligible to receive the rewards of the Reinforcing Smart Choices program.

Even if you fulfill the promise commitments, you must still earn and maintain your eligibility by working sufficient hours for a Contributing Employer to have coverage from the Plan. You may be required to get another biometric screening in order to continue to participate in the Reinforcing Smart Choices wellness program.

Newly eligible employees and their spouses will be enrolled in the plan upon meeting the Plan's initial eligibility requirements. If you and your spouse choose to participate in the Reinforcing Smart Choices wellness program and complete your requirements, you will be eligible to start receiving the incentives of the wellness program on the 1st of the month following the 90-day waiting period, provided all other requirements of the Smart Choices program have been completed.

Comparison of Copays

If you do not choose to participate in the Reinforcing Smart Choices wellness program, you will have higher Copays (and coinsurance) for certain services from Contract Providers and for prescription drugs. Please see the Schedule of Medical Benefits for a complete description of your copays.

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Deductible • The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits • The deductible is never waived. However, some services are not subject to the Deductible as noted in this Schedule of Medical Benefits. • **Note:** Deductible does not accumulate to the Annual Out-of-Pocket Limit. However, the combined Out-of-Pocket Maximum on cost sharing (deductible and Out-of-Pocket Maximum) complies with the cost sharing limitations of the ACA. • Allowed Charges incurred in the last quarter of the calendar year will be used to satisfy each individual's deductible in the following calendar year. • If two or more family members are injured in the same accident, only one deductible will apply.	**The deductible does not apply to:** • **For Contract Providers:** physician office visits (including copays), preventive care, prescription drugs, x-ray & lab (unless performed at hospital), chiropractic and acupuncture, outpatient therapy, outpatient mental health and substance abuse, emergency ground ambulance, urgent care, physician home visits, exams for podiatry, hearing exams, hearing aids, hospice care, supplemental accident, and excluded services. • **For Non-Contract Providers:** balance billed amounts, emergency ground ambulance, hearing exams, hearing aids, hospice care, supplemental accident and excluded services. **Note:** Any Deductible accumulated while you are not enrolled in the wellness program do **NOT** carry over if and when you chose to participate in the wellness program.	$250 individual $500 Family	$500 individual $1,500 Family	$500 Individual $1,500 Family	$750 Individual $2,250 Family	$250 Individual $500 Family	$500 Individual $1,500 Family

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Out-of-Pocket Limit The Out-of-Pocket Limit is the most you pay during a one year period (the calendar year) before your health plan starts to pay 100% for covered health benefits received from Contract providers. The Out-of-Pocket limit accumulates cost-sharing for any covered family member; however, no one individual in the family will be required to accumulate more than this Plan's out-of-pocket limit applicable to an individual with self-only coverage.	The Out-of-Pocket Limit for cost sharing includes medical co-payments and coinsurance. The Deductible does not accumulate to the Annual Out-of-Pocket Limit. Expenses that do not count towards the Out-of-Pocket Limit for cost sharing includes: expenses you pay for skilled nursing facility, non-covered services (i.e. excluded services), vision care, dental care, orthodontia, penalties for failure to comply with pre-authorization requirements, expenses in excess of benefit maximums, balance billed amounts, and expenses for services from Non-Contract Providers. There are separate Out-of-Pocket Limits for medical services and prescription Drugs. **NOTE:** any Out-of-Pocket amounts accumulated while you are not participating in the wellness program do **NOT** carry over if and when you choose to enroll.	Medical $2,000 Individual, $4,000 Family Prescription Drugs $2,000 Individual $4,000 Family	Unlimited	Medical $1,000 Individual, $3,000 Family Prescription Drugs $1,000 Individual $3,000 Family	Unlimited	Medical $2,000 Individual $4,000 Family Prescription Drugs $2,000 Individual $4,000 Family	Unlimited

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Hospital Services Inpatient Coverage includes: • Room and board up to the hospital's average semiprivate room rate and care in an intensive care unit and cardiac care unit, when Medically Necessary; • Hospital services and supplies provided during admission, including surgical suite, imaging procedures, laboratory tests, and therapeutic treatments; • Diagnostic, surgical, or therapeutic services provided by a hospital on an inpatient basis; • Surgery and postoperative care rendered by a Physician in a hospital. • Anesthetics and their administration; and • Services and supplies related to the surgical procedure performed.	• Does not apply to MAC inpatient procedures. **See Hospital Services for MAC procedures listed next on this Schedule of Medical Benefits.** • Pre-certification by Anthem Blue Cross is required for all inpatient procedures or you will pay an additional 10% coinsurance. To pre-certify your hospital stay, your physician's office should call Anthem Blue Cross at (800) 274-7767. • Services rendered by an assistant surgeon are covered if Medically Necessary.	90% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	90% after Deductible	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Inpatient Hospital MAC Procedures • Room and board up to the hospital's average semiprivate room rate and care in an intensive care unit and cardiac care unit, when Medically Necessary; • Hospital services and supplies provided during admission, including surgical suite, imaging procedures, laboratory tests, and therapeutic treatments; • Diagnostic, surgical, or therapeutic services provided by a hospital on an inpatient basis; • Surgery and postoperative care rendered by a Physician in a hospital; • Anesthetics and their administration; and • Services and supplies related to the surgical procedure performed.	**The following inpatient MAC limits do not apply to Arizona or Nevada Participants:** • Pre-certification by Anthem Blue Cross is required for all inpatient procedures or you will pay an additional 10% coinsurance. To pre-certify your hospital stay, your physician's office should call Anthem Blue Cross at (800) 274-7767. • Anthem can also provide a list of providers who are Value Based sites The following inpatient procedures have maximum limits on the amount that the Plan will use as the basis for payment for facility charges. The MAC limits are: • **Total hip replacement** $30,000 per procedure • **Total knee replacement:** $30,000 per procedure Services rendered by an assistant surgeon are covered if Medically Necessary.	90% of the lesser of $30,000 (MAC limit) or the Contract rate, (after Deductible)	60% after Deductible (will not exceed MAC limit)	**If you participate in the Reinforcing Smart Choices program:** 80% of the lesser of MAC limit or Contract Rate, (after Deductible) **If you do NOT participate in the Reinforcing Smart Choices program:** 70% of the lesser of MAC limit or Contract Rate (after Deductible)	60% after Deductible (will not exceed MAC limit)	90% of the lesser of $30,000 (MAC limit) or the Contract rate (after Deductible)	60% after Deductible (will not exceed MAC limit)

SCHEDULE OF MEDICAL BENEFITS Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Physician Office Visits and Physician Home Visits • Physicians' services to diagnose or treat an illness or injury that are provided in your Physician's office, a hospital, other facility, or at home are covered.		**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Allergy Services	• Medically Necessary allergy services are covered only when ordered by a Physician.	**If you participate in the Reinforcing Smart Choices program – Office visit:** 100% after a $20 copay, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program - Office Visit:** 100% after a $50 copay, Deductible does not apply **Allergy Testing, Treatment and Serum:** 80% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program - Office Visit:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program - Office Visit:** 70% after Deductible **Allergy Testing, Treatment and Serum:** 80% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program - Office Visit:** 90% after a $20 copay and the Deductible **If you do NOT participate in the Reinforcing Smart Choices program - Office Visit:** 90% after a $50 copay and the Deductible **Allergy Testing, Treatment and Serum:** 80% after Deductible	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
<u>Ambulance Services</u> (Ground vehicle emergency transportation) • Local professional ambulance service is covered subject to a Copayment (shown in the Schedule of Benefits) when the medical condition of the patient requires paramedic support. • In the event an injury or illness requires treatment that is not available in a local hospital, the Plan covers medically required ambulance service to the nearest hospital that can provide appropriate treatment.	• Transportation that is solely for the participant's convenience, personal preference (including taxi, limousine, railroad, or other non-emergency vehicle) will not be covered.	100% after a $50 copay. Deductible does not apply.	100% after a $50 copay. Deductible does not apply	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	90% after a $50 copay. Deductible does not apply	90% after a $50 copay. Deductible does not apply
<u>Ambulance</u> <u>(Air Ambulance)</u> Medically Necessary air ambulance is generally provided by and covered as a Non-Contract provider.		80% of billed charges after the Deductible		70% of billed charges after the Deductible		80% of billed charges after the Deductible	

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Chemotherapy or Radiation • Radium, radioactive isotopes, and radiation therapy.	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	90% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	90% after Deductible	60% after Deductible
Chiropractic and Acupuncture Services Combined	• Limited to a combined annual visit limit of 24 visits for all Contracted and Non-Contracted providers	**If you participate in the Reinforcing Smart Choices program:** 100% after $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 80% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Dental Care Expenses	Most expenses for dental care are covered under the dental program. However, the medical program covers expenses related to treatment of an injury to a jaw or teeth when treatment occurs within six months after the date of an accident applied without respect to when the individual is enrolled in the plan.	**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Drugs (Coverage of Prescription Drugs) • Coverage is provided for those pharmaceuticals (drugs and medicines) approved by the US Food and Drug Administration (FDA) as requiring a prescription and are FDA approved for the condition, dose, route, duration and frequency, if prescribed by a Physician authorized by law to prescribe them. • The **mail-order program is mandatory for maintenance medication**. After your 3rd prescription at a retail pharmacy for maintenance medication, you will be charged two Copays for one prescription. You save money by using the mail order prescription drug program for your long-term medication needs.		Out of Pocket Maximum for prescription drugs ***Active Plan:*** $2,000 Individual, $4,000 Family ***Z coverage***: $1,000 Individual, $3,000 Family ***A-Rodman***: $2,000 Individual/$4,000 Family Retail 30-day Supply **Generic Formulary** If you participate in the Reinforcing Smart Choices program: $10 **copay** If you do NOT participate in the Reinforcing Smart Choices program: $15 copay **Formulary Brand Name** If you participate in the Reinforcing Smart Choices program: $20 copay If you do NOT participate in the Reinforcing Smart Choices program: $35 copay **Non-Formulary Brand Name or Generic** Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. Mail Order 90-day Supply **Generic Formulary** If you participate in the Reinforcing Smart Choices program: $20 copay If you do NOT participate in the Reinforcing Smart Choices program: $30 copay **Formulary Brand Name** If you participate in the Reinforcing Smart Choices program: $40 copay If you do NOT participate in the Reinforcing Smart Choices program: $70 copay **Non-Formulary Brand Name or Generic** Not covered unless Pre-authorization is obtained. If preauthorized, paid as a formulary drug. Prescriptions from a Non-Network Pharmacy are not covered (limited exceptions for emergency)					

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Drugs (Coverage of Certain Over The Counter (OTC) Drugs) Where the information in this document conflicts with newly released Health Reform regulations affecting the coverage of OTC drugs, this Plan will comply with the new requirements on the date required.	In accordance with Health Reform regulations, certain OTC drugs are payable by this non-grandfathered medical plan including: • Aspirin – Generic aspirin products are covered for men and women from age 45 to 79 years of age • Fluoride supplementation for children to 6 years of age • Folic Acid supplements for girls/women ages 10-55 years • Iron supplementation supplements for infants up to 1 year in age • Smoking cessation drugs for two 90-day regimens per calendar year • Contraceptives all forms of generic female contraceptives (oral, diaphragms, jelly, foams, implantable, etc.). No charge for brand name if generic drug is medically inappropriate.	**No charge** if purchased at a Network Pharmacy and a prescription is received **Not covered** if purchased at a Non-Network Pharmacy					

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Employee Assistance Program (EAP) The EAP can also provide telephonic counseling for such work-life issues as: child and elder care, financial counseling, brief legal counseling and identity theft. Online assessments and referrals are also available for such issues as: smoking cessation, weight loss and health risk assessments. **HMO enrollees** may also receive these services. However, HMO enrollees must receive all additional Mental Health services from their HMO medical plan.	• **This plan offers up to 3 free EAP visits per calendar year for professional confidential counseling. The phone number for the EAP program is listed on the Important Telephone Numbers chart in the front of this document.** • After an initial assessment, employees who require additional services will be referred to either a contracted substance abuse treatment program or mental health provider or to community resources. • Please note, you are **not** required to use your EAP visits prior to receiving additional services.	No charge	Not Covered	No charge	Not Covered	No charge	Not Covered

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
<u>Emergency Room and Physician Charges</u> • Hospital emergency room (ER) for an "emergency Medical Condition" only (as defined by the Plan)." • The term "Emergency Services" means a medical screening examination and medical treatment necessary to evaluate and stabilize an individual with an Emergency Medical Condition (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility). Emergency Services must be rendered in a hospital emergency room.	• As always, you do not have to obtain pre-authorization before seeking emergency room treatment for an Emergency Medical Condition, though you or your family must call Blue Cross the next working day after admission to the hospital. • If you obtain Emergency Services from a Non-Contract Provider, the Plan generally pays a percentage of the Allowable Charges. The Plan does not pay a percentage of actual charges. If the hospital's charges exceed the Plan's Allowable Charge, you will be responsible for the difference. • The Allowed Charge for Emergency Services provided by a Non-Contracting Provider will not be less than what is required by law. • Amounts paid by the Plan for an Emergency Medical Condition with a Contract Provider will count towards the Plan's out-of-pocket maximum.	90% after Deductible	90% after Deductible. Participant coinsurance limited to $6,000 per occurrence. If it is determined the patient does not have an Emergency Medical Condition, payment will be reduced to 60% and the $6,000 coinsurance limit will not apply.	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible. Participant coinsurance limited to $6,000 per occurrence. **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible. Participant coinsurance limited to $6,000 per occurrence. If it is determined the patient does not have an Emergency Medical Condition, payment will be reduced to 60% and the $6,000 coinsurance limit will not apply.	90% after $100 copay and Deductible	90% after $100 copay and Deductible. Participant coinsurance limited to $6,000 per occurrence. If it is determined the patient does not have an Emergency Medical Condition, payment will be reduced to 60% and the $6,000 coinsurance limit will not apply.

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Family Planning • No cost-sharing for female sterilization when performed by Contract providers • No cost sharing for FDA-approved female contraceptives	• Services for treatment of infertility are **not covered**. • Reversal of a tubal ligation or vasectomy is not covered.	**Contraceptive Devices, and Tubal Ligation:** 100%, Deductible does not apply **Vasectomy and Elective Abortions**: 80% after Deductible	60% after Deductible	**Contraceptive Devices, and Tubal Ligation:** 100%, Deductible does not apply **Vasectomy and Elective Abortions:** **If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	**Contraceptive Devices, and Tubal Ligation:** 100%, Deductible does not apply **Vasectomy and Elective Abortions**: 80% after Deductible	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Genetic testing	• Pre-authorization is required (except for screenings that are required to be covered under Health Reform) by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271.	**If you participate in the Reinforcing Smart Choices program - Office Visit:** 100% after a $20 copay, Deductible does not apply **If you do not participate in the Reinforcing Smart Choices program - Office Visit:** 100% after a $50 copay, Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program: Office Visit:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program: Office Visit:** 70% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program - Office Visit:** 90% after a $20 copay and the Deductible **If you do NOT participate in the Reinforcing Smart Choices program - Office Visit:** 90% after a $50 copay and the Deductible	60% after Deductible
Hearing Care	• Exams are limited to one per calendar year. • Coverage is limited to one device per ear, not more often than once every three years from the date of the last purchase. • The $2,000 maximum per hearing aid is a combined maximum for all Contract and Non-Contract charges. • Replacement batteries are not covered.	**Exam:** 100%, Deductible does not apply **Hearing Aids:** 90% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam:** 100%, Deductible does not apply **Hearing Aids:** 90% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam:** 100%, Deductible does not apply **Hearing Aids:** 80% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exams:** 100%, Deductible does not apply **Hearing Aids:** 80% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam:** 100%, Deductible does not apply **Hearing Aids:** 90% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply	**Exam:** 100%, Deductible does not apply **Hearing Aids:** 90% of the lesser of $2,000 per device or the Contract Rate. Deductible does not apply

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Home Health Care		90% after Deductible and a $20 copay	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	80% after Deductible and a $20 copay.	60% after Deductible
Hospice • Intermittent nursing care provided by a graduate registered nurse or licensed practical nurse under the supervision of a registered nurse for the terminally ill patient. Terminally ill means an individual with less than six months to live. • Medical social services provided prior to death by a licensed social worker • Bereavement counseling during the three-month period following the death of the terminally ill patient.		100%, Deductible does not apply	100%, Deductible does not apply	100%, Deductible does not apply	100%, Deductible does not apply	100%, Deductible does not apply	100%, Deductible does not apply

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Laboratory Services (in office or facility other than a Hospital)	Lab services require pre-authorization by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	**If you participate in the Reinforcing Smart Choices program:** 100% after $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Medical Supplies, Orthopedic Braces, Prosthetic Appliances Subject to approval by the Trust Fund Office, rental (or purchase, if cost effective) of Medically Necessary supplies, equipment and prosthetics. Coverage includes: • Casts, splints, orthotic devices, braces, crutches, and surgical dressings. • Blood, blood plasma, and its administration. • Oxygen and its administration. • Artificial limbs and eyes. • Breast prosthesis following a mastectomy; subsequent prosthesis ordered by a Physician. • Initial purchase of eyeglasses or contact lenses as a result of cataract surgery.	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271 for all medical supplies costing more than $500. • For females who are breastfeeding, coverage is provided for one standard manual or standard electric breast pump, plus the breast pump supplies needed to operate the breast pump. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child. Rental, purchase and repair is payable. • In lieu of a customized brace, the Fund will allow one over-the-counter brace if Medically Necessary, prescribed by a Physician and purchased within the first 31 days following a covered surgery or accident.	**Breast Pump:** 100%, Deductible does not apply **All other covered Medical Supplies, Orthopedic Braces and Prosthetic Appliances:** 80% after Deductible	60% after Deductible	**Breast Pump:** 100%, Deductible does not apply **All other covered Medical Supplies, Orthopedic Braces and Prosthetic Appliances:** **If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	**Breast Pump:** 100%, Deductible does not apply **All other covered Medical Supplies, Orthopedic Braces and Prosthetic Appliances:** 80% after Deductible	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Mental Health Treatment • Please also refer to the Substance Abuse Row of this Schedule for available benefits.	• Mental Health services are available through Managed Health Network (MHN). All inpatient services including alternate levels of care (except emergency hospitalization) must be pre-authorized by MHN or you will pay an additional 10% coinsurance. • In cases of emergency, the patient or a family member must contact MHN as soon as possible, but no later than 72 hours after an inpatient admission at (800) 977-7962. • No benefits are provided for pervasive developmental delay, learning disabilities or that are primarily provided to enhance academic achievement of Dependent children.	Inpatient: 90% after Deductible Outpatient: **If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay, Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	Inpatient: 90% after Deductible Outpatient: **If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay, Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Outpatient Surgery Facility for Procedures not Subject to MAC • Ambulatory (Outpatient) Surgical Facility/Center (e.g. surgicenter, same day surgery, outpatient surgery).	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	90% after Deductible	Maximum benefit of $350 per day after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	Maximum benefit of $350 per day after Deductible	90% after Deductible	Maximum benefit of $350 per day after Deductible
Outpatient Surgery Facility Fee (for MAC procedures) The following outpatient procedures have maximum limits on the amount that the Plan will use as the basis for payment for Facility charges: • Arthroscopy • Cataract • Colonoscopy	The following MAC limits apply to ALL participants: • **Arthroscopy** $6,000 per procedure • **Cataract Surgery** $2,000 per procedure • **Colonoscopy** $1,500 per procedure Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271.	90% of the lesser of the MAC limit or the Contract Rate after Deductible	Maximum benefit of $350 per day for all Non-Contract outpatient surgical procedures after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% of the lesser of the MAC limit or the Contract Rate after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% of the lesser of the MAC limit or the Contract rate after Deductible	Maximum benefit of $350 per day for all Non-Contract outpatient surgical procedures after Deductible	90% of the lesser of the MAC limit or the Contract Rate after Deductible	Maximum benefit of $350 per day for all Non-Contract outpatient surgical procedures after Deductible

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Outpatient Surgery Physician and/or Surgeon fee	Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	90% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	90% after Deductible	60% after Deductible
Physical Therapy and Respiratory Therapy, Combined • Only care that demonstrates progressive improvement in the patient's functional capacity is covered.	• Maximum benefit of 20 visits per calendar year (for all Contract and Non-Contract providers combined) • If pre-approved by case management as Medically Necessary, the Fund may allow 20 additional therapy visits after major surgery, stroke or a heart attack. • Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271. • No benefits are provided for pervasive developmental delay.	**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 80% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Podiatry Exam	• Orthotic appliances are covered for the Employee only	Office Visits **If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply Orthotic Appliances for Employee only 80% after Deductible up to a maximum benefit of $200 per calendar year	**Office Visits**: 60% after Deductible **Orthotic appliances**: Not covered	Office Visits **If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible Orthotic Appliances for Employee only 80% after Deductible up to a maximum benefit of $200 per calendar year	Office Visits 60% after Deductible Orthotic Appliances Not covered	Office Visits **If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay Deductible does not apply Orthotic Appliances for Employee only 80% after Deductible up to a maximum benefit of $200 per calendar year	**Office Visits**: 60% after Deductible **Orthotic Appliances:** Not covered

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Radiology, X-ray (Complex Services) including but not limited to MRI, PET and CAT scans	• Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling service at (855) 754-7271	90% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	90% after Deductible	60% after Deductible
Radiology, X-ray (Non-Complex Services) in office or facilities other than Hospital • Diagnostic x-rays	• X-rays performed outside of your Physician's office require pre-authorization by calling Pacific Heath Alliance (PHA) Care Counseling Service. • Some radiology procedures are covered under the Preventive Care Program described in this Schedule.	**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Radiology, X-ray (Non-Complex Services) at a Hospital • Diagnostic x-rays	• X-rays performed at a Hospital require pre-authorization by calling Pacific Heath Alliance (PHA) Care Counseling Service. • Some radiology procedures are covered under the Preventive Care Program described in this Schedule.	90% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	90% after Deductible	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Reconstructive Services and Breast Reconstruction After Mastectomy This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) that indicates that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including: • reconstruction of the breast on which the mastectomy was performed; • surgery and reconstruction of the other breast to produce a symmetrical appearance; and • Prostheses and physical complications for all stages of mastectomy, including lymphedemas.	Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271 (or Anthem if the procedure is done in the Hospital as part of an inpatient confinement). The Plan will cover Medically Necessary reconstructive surgery, procedures or treatment intended to improve bodily function and/or correct a deformity resulting from disease, infection, trauma, or congenital anomaly in a child that causes a functional defect or results from a prior therapeutic procedure. Please contact the Trust Fund Office to determine if a proposed surgery or service will be considered cosmetic surgery or Medically Necessary. In order to determine Medical Necessity, the Plan reserves the right to request any and all medical records, including but not limited to: history and physical reports, chart notes, test results, operative reports, pathology reports and pre-operative color photos.	90% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	90% after Deductible	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Skilled Nursing Facility (SNF) • Charges for room and board and other services and supplies, not including fees for professional services.	• Participant payments for SNF do not accumulate to the annual Out-of-Pocket maximum	45% after Deductible up to 55 days per disability	35% after Deductible up to 55 days per disability	45% after Deductible up to 55 days per disability	35% after Deductible up to 55 days per disability	45% after Deductible up to 55 days per disability	35% after Deductible up to 55 days per disability
Speech Therapy and Occupational Therapy combined	• Annual Maximum of 20 visits per calendar year for all Contract Provider and Non-Contract Provider Services. • Pre-authorization is required by calling Pacific Health Alliance (PHA) Care Counseling services at (855) 754-7271	**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 80% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** $50 copay Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
<u>Substance Abuse Treatment</u> • Active Employees enrolled in an HMO may also receive these services.	• Substance abuse benefits are available for Active Employees only (not Dependents). • All inpatient services including alternative levels of care (except emergency hospitalization) must be pre-authorized by MHN (800) 977-7962 or you will pay an additional 10% coinsurance. • In cases of emergency, the patient or a family member must contact MHN as soon as possible, but no later than 72 hours after an inpatient admission at (800) 977-7962.	<u>Inpatient Care (including alternate levels of Care):</u> 90% after Deductible <u>Outpatient Care</u> **If you participate in the Reinforcing Smart Choices program:** $20 copay, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** $50 copay, Deductible does not apply	60% after Deductible	<u>Inpatient Care (including alternate levels of Care)</u> **If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible <u>Outpatient Care</u> **If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	<u>Inpatient Care (including alternate levels of Care)</u> 90% after Deductible <u>Outpatient Care</u> **If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay, Deductible does not apply **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay, Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Supplemental Accident Coverage Covered Charges include: • Medical and surgical treatment; and/or • Hospital services. • Services provided by a registered nurse or physical therapist. • Laboratory and x-ray services related to the injury. • Injuries sustained to the teeth or gums related to the accident.	• Charges must be incurred within 90-days of accident (applied without respect to when the individual was enrolled in the Plan) up to $300 for medical and $100 for x-ray and lab services per accident. There are no benefits available for: • Treatment beginning after 90 days of the date the injury occurred. • Ptomaine poisoning. • Disease or infections other than those related to the injury. • Eye glasses. • Hearing aids. • Injuries sustained in an altercation, however, this exclusion does not apply to any injury that results from a medical condition or domestic violence.	Not Applicable	100%, Deductible does not apply up to maximum payments. Remaining covered charges are subject to normal Plan provisions for Non-Contract claims.	Not Applicable	100%, Deductible does not apply up to maximum payments. Remaining covered charges are subject to normal Plan provisions for Non-Contract claims.	Not Applicable	100%, Deductible does not apply up to maximum payments. Remaining covered charges are subject to normal Plan provisions for Non-Contract claims.

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Temporomandibular Joint Dysfunction (TMJ) treatment	• Limited to a lifetime maximum of $1,000 per person.	**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay Deductible does not apply	60% after Deductible
Urgent Care		**If you participate in the Reinforcing Smart Choices program:** 100% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 100% after a $50 copay Deductible does not apply	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 80% after Deductible **If you do NOT participate in the Reinforcing Smart Choices program:** 70% after Deductible	60% after Deductible	**If you participate in the Reinforcing Smart Choices program:** 90% after a $20 copay **If you do NOT participate in the Reinforcing Smart Choices program:** 90% after a $50 copay Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Wellness/Preventive Care for Children Covered Services include but are not limited to: • Newborn screening lab tests (typically payable as part of hospitalization at birth); • At least 11 office visits payable during first 30 months of age, then annual office visits are payable from age 3 years through age 18 years; • Hemoglobin and lead blood tests in first year of life; • Screening for hepatitis B virus infection; • Application of fluoride varnish to the primary teeth of all infants and children up to age 5 starting at the age of primary tooth eruption, in primary care practices; • Tuberculosis (TB) skin test in first year of life; • Hemoglobin blood test in second year of life; and • CDC recommended immunizations. See row titled "Weight Management" for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss. Where the information in this document conflicts with newly released Health Reform regulations affecting coverage, this Plan will comply with the new requirements on the date required.		100%, Deductible does not apply	60% after Deductible	100%, Deductible does not apply	60% after Deductible	100%, Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Wellness/Preventive Care for Men Covered Services include but are not limited to: • Abdominal aortic aneurysm screening; • Colonoscopy, sigmoidoscopy or fecal occult blood test beginning at age 50 (including anesthesia services, a pre-op consult and a pathology exam on a polyp biopsy provided in connection with the procedure). • Five blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV; • Screening for hepatitis B virus infection; • Tobacco Use screening for all adults and cessation interventions for tobacco users. This includes four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and • CDC recommended immunizations. See row titled "Weight Management" for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss. Where the information in this document conflicts with newly released Health Reform regulations affecting coverage, this Plan will comply with the new requirements on the date required.		100%, Deductible does not apply	60% after Deductible	100%, Deductible does not apply	60% after Deductible	100%, Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS							
Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.							
Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Wellness/Preventive Care for Women (including pregnant women) Covered Services include but are not limited to: • Well women office visits; • Screening for gestational diabetes, HPV testing at least every 3 years starting at age 30, counseling on sexually transmitted infections, rental/purchase of breastfeeding equipment and necessary supplies, lactation support (for duration of breastfeeding); • Sterilization procedures, patient education and counseling; • Many services necessary for prenatal care; • Low-dose aspirin after 12 weeks of gestation for women who are at high risk for preeclampsia; • Screening mammogram for breast cancer; • Pap smear and Chlamydia screening; • Osteoporosis screening x-ray; • Colonoscopy, sigmoidoscopy or fecal occult blood test beginning at age 50 (including anesthesia, pre-op consult and pathology exam on a polyp biopsy provided in connection with the procedure); • Blood tests for cholesterol/lipid, blood sugar, gonorrhea, syphilis, HIV; • Screening for hepatitis B virus infection; • Tobacco use screening, cessation interventions for tobacco users and expanded counseling for pregnant tobacco users. This includes four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and • BRCA 1 and 2 lab test with family history of breast cancer See row titled "Weight Management" for coverage of obesity screening and intensive counseling and behavioral interventions to promote sustained weight loss. Where the information in this document conflicts with newly released Health Reform regulations affecting coverage, this Plan will comply with the new requirements on the date required.		100%, Deductible does not apply	60% after Deductible	100%, Deductible does not apply	60% after Deductible	100%, Deductible does not apply	60% after Deductible

SCHEDULE OF MEDICAL BENEFITS

Important: Contract Providers Are Paid According to the PPO Contracted Rate. Non-Contract Providers are paid according to the Allowed Charge and could result in balance billing to you.

Benefit Description	Explanations and Limitations	Active Plan		Z Coverage		A Rodman	
		Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider	Contract Provider	Non-Contract Provider
Weight Management • Bariatric surgeries include a variety of procedures intended to assist significant weight loss, including but not limited to: lap-band surgery, gastric bypass surgery, and gastric banding surgery. • As a **preventive counseling benefit** in compliance with Health Reform, the Plan covers Physician prescribed intensive behavioral counseling interventions. For children age 6 years and older with obesity, the Plan covers Physician prescribed intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's in-network pediatrician.	• Surgical treatments for Morbid Obesity (such as bariatric surgery may be covered under normal plan benefits (subject to any deductible, copays and/or coinsurance) if the surgery is performed at an Anthem Blue Distinction facility and is pre-authorized by Anthem. • Charges for weight loss programs such as Weight Watchers and Jenny Craig's are not covered.	**Preventive Counseling:** 100%, Deductible does not apply **Surgical treatment** is subject to normal plan benefits	60% after Deductible	**Preventive Counseling:** 100%, Deductible does not apply **Surgical treatment** is subject to normal plan benefits	60% after Deductible	**Preventive Counseling:** 100%, Deductible does not apply **Surgical treatment** is subject to normal plan benefits	60% after Deductible

Fee-For-Service Medical Plan Allowed Charges

The Fee-For-Service Medical Plan covers a portion of the charges to the extent that they are:

- Medically necessary;
- Not in excess of the Plan's Allowed Charges or the Contract Rate;
- Due to illness or injury;
- Performed or ordered by a Physician;
- Incurred while you and your eligible Dependents are eligible under the Plan; or
- Within any maximum benefit limits specified by the Plan.

Expenses that are Not Covered Under The Fee-For-Service Medical Plan

Although the medical program covers many services and supplies, it does not cover everything. Following is a list of expenses that are not covered:

- Any services or supplies that are not Medically Necessary as determined by the Plan Administrator or its designee.
- Dental services and supplies (except as specifically provided for).
- Treatment for substance abuse disorders for Dependents (benefits are provided for Active Employees only) except for preventive screenings covered under the Affordable Care Act.
- Bodily injury or sickness arising out of, or in the course of, employment, including self-employment.
- Services and supplies furnished by any person, hospital or other provider organization who or which, regardless of the patient's financial ability, do not require payment in any amount from the patient.
- Services and supplies furnished by a hospital or facility operated by the federal government or any authorized agency thereof, or furnished at the expense of such government or agency, except to the extent that such services are reimbursable to the Veterans Administration to the extent required by federal law under 38 U.S.C. 629 for non-service connected conditions.
- Cosmetic 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 or surgical treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. The Plan complies with the Women's Health and Cancer Rights Act of 1998. Refer to the *Glossary of Defined Terms* for the definition of Cosmetic Surgery.
- Injuries or illness resulting from any form of, or aggravated by, warfare or invasion or while on active duty with the Uniformed Services.
- Treatment received from a relative or member of the patient's household.
- Charges in excess of the Plan's Allowable Charge (refer to the Plan's *Glossary of Defined Terms*).
- Experimental or Investigative procedures (refer to the Plan's *Glossary of Defined Terms*), except as otherwise permitted.
- Services and supplies not recommended or approved or prescribed by a Physician.
- Orthopedic shoes or other wearing apparel except as specifically provided for.
- Orthotics for any or Dependent

- Vitamins, health foods, dietary supplements, consultations regarding food or nutrition, diabetic training and education (except as otherwise covered under the Affordable Care Act).
- Exercise equipment, whirlpools, Jacuzzis, saunas, pillows and non-prescription items.
- Eye refractions and any surgical procedure to correct refractive errors of the eyes.
- Custodial Care (refer to the Plan's *Glossary of Defined Terms*).
- Reversal of sterilization.
- All services related to infertility treatment, including but not limited to In Vitro Fertilization, Assisted Reproductive Technology and fertility drugs.
- All services related to any surrogate parenting arrangement, including but not limited to maternity care, obstetrical care and medical expenses of any child born out of any surrogacy arrangement (except as otherwise covered under the Affordable Care Act).
- Charges related to the treatment of obesity, other than bariatric surgical intervention for Morbid Obesity (refer to the Glossary of Defined Terms) and coverage for counseling as required under the Affordable Care Act. If your Physician prescribes bariatric surgery, pre-authorization from Anthem Blue Cross is required. Coverage of bariatric surgery will only be covered if the surgery is performed at an Anthem Blue Cross Blue Distinction Center for Bariatric Surgery.
- Charges for services provided outside the United States except for Emergency care.
- Expenses incurred due to participation in a Clinical Trial that are: (1) the investigational items, devices, services, or drugs being studied as part of the Clinical Trial; (2) items, devices, services, and drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services, or drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.
- Any services received after termination of eligibility except as provided for in the section of this ***SPD*** called *Coverage After Termination*.
- Educational Services are not covered even if they are required because of an injury, illness or disability of a Participant including but not limited to supplies or equipment, including, but not limited to computers, computer devices/software, printers, books, tutoring or interpreters, visual aides, vision therapy, auditory or speech aids/synthesizers, auxiliary aids, communication boards, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members, and implantable medical identification/tracking devices.
- No payment shall be made for court-ordered services, except for those services that are otherwise deemed to be Medically Necessary and appropriate.
- No payment shall be made for injury or illness arising out of or in the course of employment, including self-employment.
- Non-emergency care when traveling outside the U.S.

Fee-For-Service Prescription Drug Benefits

Prescription Drug Manager

Prescription drug coverage can play an important role in your overall health. Recognizing the importance of this coverage, the Plan has contracted with a Prescription Drug Manager listed under the *Important Telephone Numbers* section of this booklet. The Prescription Drug Manager features a network of conveniently located participating pharmacies and a mail order program. When you have your prescriptions filled at a participating pharmacy or through the mail order program, you save money for yourself and the Plan.

When you have a prescription filled at a participating pharmacy:

- Present your ID card.
- Pay your Copay.

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

Out-of-Pocket Limit for Prescription Drugs from a Network Pharmacy

The Out-of-Pocket Limit is the most you pay during a calendar year before your health plan starts to pay 100% for covered In-Network prescription drugs. The family out-of-pocket limit accumulates Copays for covered In-Network drugs for any covered family member; however, no one individual in the family will be required to accumulate more than their individual Out-of-Pocket amount. Please refer to the Schedule of Medical Benefits for a complete description of your Out-of-Pocket limit.

Pre-Authorization

Non-Formulary Drugs

Your Physician must obtain pre-authorization from EnvisionRx before the Plan will reimburse non-formulary generic or brand drugs. No coverage will be allowed without pre-authorization. If pre-authorization is obtained, the drug will be paid as a formulary drug (if it is purchased at an In-Network pharmacy). If your Physician feels that a non-formulary drug is not medically viable for your medical condition, you may file an appeal or your Physician can request an exception by contacting EvisionRx.

Preferred Formulary Drugs

If you are taking a prescription drug for one of the drug categories listed below in the "PA Category", such as for treatment of Benign Prostatic Hyperplasia (BPH) and Erectile Dysfunction (ED), the Plan will only provide coverage for the "Preferred Formulary Alternative." If you attempt to fill a prescription for a drug that requires pre-authorization (PA) listed in the PA category below without first receiving pre-authorization from EnvisionRx, there will be no payment by the Plan. If you have already tried the recommended alternative medication, your Physician can request an exception by contacting EnvisionRx. If the request is not approved, you will be responsible for the full price of the drug.

PA Category	Criteria
Benign Prostatic Hyperplasia (BPH) and Erectile Dysfunction (ED), Cialis®, Staxyn®, Stendra®	If a patient has a diagnosis of BPH, he must have tried and failed BOTH a generic alpha reductase inhibitor AND a generic alpha 1 adrenergic blocker (for at least 6 months) prior to approval of Cialis®. If a patient has a diagnosis of ED, the patient must have tried and failed Levitra or Viagra prior to approval of Cialis®, Staxyn® or Stendra®.

Compound Medications

A Compound Drug is any drug that has more than one active ingredient, at least one of the active ingredients is a Federal Legend Drug or a drug that requires a prescription under state law, and a pharmacist must combine, mix, or alter the ingredients to create a medication tailored to the medical needs of an individual patient.

Some compound drugs are only available at a retail pharmacy location, not mail order. Others may be available by mail order.

To help ensure that the drugs covered by the Plan are used safely and appropriately, the Plan has a preapproval process for compound drugs. For compound drugs prescriptions with a retail cost of $200 or more, a letter of medical necessity from your physician must be provided to EnvisionRx. The letter will be reviewed by the clinical team at EnvisionRx to determine whether there are benefits available for the compound drug. No benefits will provided without preapproval. If your request is denied, you may file an appeal with the Fund.

Retail Pharmacy Program

You will receive a prescription drug ID card. When you have a prescription filled at a participating pharmacy and show the pharmacist your ID card, you will be responsible for the Copay listed in the Schedule of Medical Benefits.

Important: If you use a non-participating pharmacy, no benefits are payable. There is a limited exception for emergencies. You will need to pay the full cost of the prescription and file a claim with EnvisionRx for direct reimbursement.

Mail Order Program

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

Covered Drugs and Medications

The Plan covers legend drugs that require a written prescription from a Physician or dentist. In addition, the Plan covers certain over-the-counter medications to the extent that a written prescription from a Physician is provided. A licensed pharmacist must dispense these prescriptions. You must use a

participating pharmacy or the mail order program. If you use a non-participating pharmacy, no benefits are payable.

Preferred Formulary Drugs

Within each drug category, there are many therapeutic alternative drugs available on the Formulary. If you are taking a prescription drug for one of the drug categories listed below, the Fund will only provide coverage for the "Preferred Formulary Alternative," listed below. If you attempt to fill a prescription for one of the "Non-Covered Drugs" listed below, there will be no payment by the Plan. If your Physician feels that you must have access to a Non-Covered Drug instead of the Preferred Formulary Alternative, you may file an appeal with the Plan or your Physician can request an exception by contacting EnvisionRx.

Drug Category	Non-Covered Drug	Preferred Formulary Alternative
Acne	Absorica®	Amnesteem®, Claravis®, Myorisan®, Zenatane®
Androgens	Androderm®, Axiron®, Fortesta®	Androgel®, generic testosterone (Testim)
Diabetes/Glucose testing supplies	Accu-Chek®, OneTouch®	Breeze®, Contour®, FreeStyle®, Precision®
Insulin	Humalog®, Humulin®	Novolog®, Novolin®
Injectable Anti-diabetic	Bydureon®, Byetta®	Victoza®
Overactive Bladder	Toviaz®	Oxbutynin, tolterodine, Vesicare®

Step Therapy

There are many medications within each drug category. Frequently, the newest drug being marketed is also the most expensive option and not necessarily the most effective. In fact, many times a less costly drug can provide the same medical results.

If you are prescribed one of the medications listed below in the "Step 2 Medication List" column, you must have tried and failed one of the medications in the "Step 1 Medication List" column before the Fund will cover the Step 2 Medication. If your Physician feels that you must have access to the Step 2 drug without trying the Step 1 drug, you may file an appeal with the Fund or your Physician can request an exception by contacting EnvisionRx.

Diagnosis	Step 2 Medication List *	Step 1 Medication List (Criteria For Coverage)
ADD/ADHD	Daytrana®, Focalin XR®, Quillivant®, Ritalin LA®	Must have tried and failed Vyvanse and a generic ADD/ADHD medication prior to using a Step 2 medication.
Asthma	Proventil HFA®, Xopenes HFA®	Must have tried and failed Proair HFA® or Ventolin HFA® prior to using a Step 2 medication.
Diabetes	Jentadueto®, Tradjenta®	Must have tried and failed Janumet®, Januvia®, Kombiglyze® or Onglyza® prior to using a Step 2 medication.

Diagnosis	Step 2 Medication List *	Step 1 Medication List (Criteria For Coverage)
Inflammatory Bowel Disease	Asacol HD®, Delzicol®, Pentasa®	Must have tried and failed Apriso® or Lialda® prior to using a Step 2 medication.
Opioid Abuse	Buprenorphine/naloxone, Zubsolv®	Must have tried and failed Suboxone® Film prior to using a Step 2 medication.
Stimulants	Modafinil	Must have tried and failed Nuvigil® prior to using a Step 2 medication.
Multiple Sclerosis	Aubagio®, Betaseron®, Extavia®, Gilenya®, Rebif®	Must have tried and failed Avonex®, Copaxone®, or Tecfidera® prior to using a Step 2 medication.
Rheumatoid Arthritis	Stelera®, Simponi®, Cimzia®, Xeljanz®, Actemra®, Orencia®, Kineret®	Must have tried and failed Enbrel® and Humira® prior to using a Step 2 medication.
Growth Hormone	Humatrope®, Nutropin AQ®, Omnitrope®, Saizen®, Tev-Tropin®	Must have tried and failed Genotropin® or Norditropin® prior to using a Step 2 medication.
Angiotension Receptor Blocker	Edarbi/HCT®, Micardis/HCT®, Hyzaa®, Cozaar®, Avapro®, Afalide®, Atacand/HCT®, Teveten/HCT®, Benicar/HCT®	Must have tried and failed a Losartan/HCT, Valsartan HCT, or Irbesartan/HCT prior to using a Step 2 medication.
Antidepressant	Brintellix®	Must have tried and failed a generic anti-depressant prior to using a Step 2 medication.

* *If you are taking one of the Step 2 medications as of March 1, 2015, you may continue to do so without first trying a medication in the Step 1 column.*

New-To-Market Drugs

As noted above, Fund contracts with EnvisionRx, a PBM firm, to administer the outpatient prescription drug benefits for the Plan, including determining the medications that are appropriate for the Plan's formulary list of preferred drugs. Any medication that is newly approved by the U.S. Food and Drug Administration (FDA) to enter the market is not covered under the EnvisionRx Formulary until after a clinical review and a decision to include such drug on the EnvisionRx Formulary have been made by the EnvisionRx Pharmacy and Therapeutics Committee. This means that if you attempt to fill a prescription for one of these "new to market" drugs, before the EnvisionRx Pharmacy and Therapeutics Committee has completed its review, there will be no payment by the Plan. If your Physician feels that you must have access to this "new to market" medication before the EnvisionRx Pharmacy and Therapeutic Committee completes its review, you may file an appeal with the Fund.

Over-the-Counter Drugs

The following medication is covered at no cost to you if the medication is received from a Network Pharmacy and a prescription is received.

Medication *	Description of Coverage
Aspirin	All generic aspirin products (including OTC) are covered for men and women from age 45 to 79 years of age.
Fluoride	All fluoride supplementation for children to 6 years of age.
Folic Acid	All folic acid supplements for girls/women aged 10-55 years.
Iron supplementation	All liquid iron supplements for infants up to 1 year in age.
Smoking cessation	Medically appropriate coverage for FDA-approved tobacco cessation drugs (including both prescription and over-the-counter) are payable for up to two 90-day treatment regimens per year, which applies to all products.
Over-the-counter contraceptives	All forms of contraceptives for women are covered (oral, diaphragms, jelly, foams, implantable, etc.)
Bowel Preparation "prep" products.	Covered prior to a colon cancer screening test

* Where the information in this chart conflicts with newly released Affordable Care Act regulations affecting preventive care drug coverage, this Plan will comply with the new requirements on the date required.

Expenses Not Covered Under the Prescription Drug Program

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

- Prescriptions obtained at a non-participating pharmacy (except for limited exceptions for emergency prescriptions).
- Prescriptions dispensed by a licensed hospital during confinement (including "take-home" prescriptions).
- Drugs or medications that may be procured without a Physician's written prescription (except as otherwise required to be covered under the Affordable Care Act).
- Appliances or prosthetics.
- Prescriptions for conditions arising out of, or in the course of, employment, including self-employment.
- Any non-drug item.
- Drugs used to promote hair growth.
- Drugs for which reimbursement is provided by a governmental agency except to the extent that the Veterans Administration may request reimbursement for prescriptions to treat illness or injury that is not related to service in the Armed Forces.
- Multiple and non-therapeutic vitamins and dietary supplements, except as otherwise required by the Patient Protection and Affordable Care Act.
- Health and beauty aids.

- Drugs that are not Medically Necessary.
- Retin-A for anyone over 25 years of age.

How to File a Prescription Claim

If you have an emergency and need to fill a prescription at the pharmacy that does not participate with the network of participating pharmacies administered by the PBM, you will need to fill out a claim form. The claim form is available on the or from the Trust Fund Office.

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

Send your claim to:

Envision/Rx Options, Inc.
2181 East Aurora Road, Suite 201
Twinsburg, OH 44087

For questions, please contact EnvisionRx directly at 1-800-361-4542.

Dental Benefits

Dental benefits are treated as a standalone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordability Care Act of 2010 (PPACA). However, the Trustees have decided to allow dental coverage for Dependents up to age 26 even though it is not required to do so.

Choice of Dental Plans

This Chapter describes the **Fee-For-Service Dental Plan.** Depending on your geographic area, you may have the option to enroll in a prepaid dental plan. Prepaid plans operate similarly to the medical HMOs where covered procedures are paid 100% after you pay the required Copay. Copays vary by procedure and plan. Please refer to the *Evidence of Coverage* and Plan Summaries provided by the dental carrier for more information. The section called *Important Telephone Numbers* in the front of this ***SPD*** shows which carriers are available in each state.

Contract Providers

The Plan also contracts with a preferred provider network, Delta Dental. If you receive covered dental treatment at one of the preferred dentists, you will have no out-to-pocket expenses except for the deductible and charges exceeding the calendar year maximum. The calendar year maximum does not apply to pediatric dental services for Dependent children under age 19. Please refer to the *Important Telephone Numbers* in the front of this SPD for information on how to contact Delta Dental and to find out how to access a listing of dental network providers.

Pre-Determination of Benefits

It is strongly recommended that if your dentist proposes services that exceed $200 that you request that he or she submit the proposed claim for a pre-determination review to Delta Dental for a determination of whether the services will be covered. A pre-determination review is also strongly recommended for any orthodontic treatment proposed for a Dependent child.

Calendar Year Deductible

Each eligible individual must satisfy a $50 calendar year deductible before the Plan pays for any covered services. Each family is only responsible for three times the individual deductible each year. Covered charges incurred in the last quarter of the calendar year also will be applied to the following calendar year's deductible. Orthodontia benefits are not subject to the annual deductible.

Calendar Year Maximum Benefits

The maximum benefits paid for each covered individual in a calendar year does not apply to pediatric dental services for Dependents under age 19. Orthodontia benefits are subject to a separate lifetime maximum.

Summary of Benefits and Covered Services

The following summary of benefits outlines the benefits payable depending on whether you choose to receive services from a Delta Dental PPO dentist, Premier dentist or Non-Delta Dental dentist. You will maximum your savings and receive the greatest benefits by visiting a PPO dentist.

SCHEDULE OF DENTAL BENEFITS			
Benefits and Covered Services	**Delta Dental PPO dentists ****	**Delta Dental Premier dentists ****	**Non-Delta Dental dentists ****
Deductible	$50 per person/$150 per family per calendar year		
Annual Maximum	$3,000 per person	$2,000 per person	$1,500 per person
Diagnostic & Preventive Services (Exams, cleanings and x-rays)	100%	100%	80%
Basic Services (fillings and sealants)	100%	80%	50%
Endodontics (root canals) Covered under Basic Services	100%	80%	50%
Periodontics (gum treatment) Covered under Basic Services	100%	80%	50%
Oral Surgery (Covered under Basic Services)	100%	80%	50%
Major Services (Crowns, inlays, onlays and cast restorations)	100%	80%	50%
Prosthodontics (Bridges, dentures and implants)	100%	80%	50%
Orthodontic Benefits (for Dependent Children only)	50%	50%	50%
Lifetime Orthodontic Maximum (Deductible waived)	$1,000	$1,000	$1,000

** Reimbursement is based on PPO contracted fees for PPO dentists, Premier contracted fees for Premier dentists and program allowance for non-Delta Dental dentists

Covered Dental Expenses

Diagnostic and Preventive Benefits

Provides all necessary procedures to assist the dentist in evaluating the existing condition of your teeth including:

- Oral exams (two per calendar year);
- Two cleanings per calendar year. Upon written confirmation of your pregnancy, Delta Dental may allow an additional routine cleaning;
- a full mouth series of x-rays (once in a 12-month period), one panoramic x-ray only after 12 months have elapsed since any prior panoramic x-ray was provided under any Delta Dental plan, bitewing x-rays upon request by the dentist but no more than twice in any calendar year for children to age 18 or once in any calendar year for adults 18 and over while you are eligible under any Delta Dental Plan;
- diagnostic casts (only when made in connection with subsequent covered orthodontic treatment);
- exam of biopsied tissue;
- palliative emergency treatment;

- specialist consultation;
- fluoride treatment;
- space maintainers; and
- sealants through age 16 if teeth are without decay or restoration.

Basic Benefits

Covered Basic benefits include oral surgery, extractions, amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions, endodontic treatment of the tooth pulp, periodontic treatment of gums and bones that support the teeth, general anesthesia, I.V. sedation.

Crowns, Inlays, Onlays and Cast Restoration Benefits

Covered benefits include crowns, inlays, onlays and cast restorations only if they are provided to treat cavities that cannot be restored with amalgam, silicate or direct composite (resin) restorations.

Prosthodontic Benefits

Provides bridges, partial dentures, complete dentures, and dental implants (removal of implant once for each tooth) if provided to replace missing, natural teeth. Replacement will only be covered if the existing appliance is unsatisfactory and cannot be made satisfactory. If Delta Dental has paid for the existing appliance, replacement will not be made until five years have elapsed from the date the expense was incurred for the existing appliance, unless:

- The replacement is necessary due to the initial placement of an opposing full denture or the extraction of natural teeth;
- The appliance is temporary and is being replaced by a permanent appliance; or
- The appliance was damaged beyond repair by an injury.

Orthodontic Benefits

The Plan will cover standard orthodontic treatment associated with the straightening and realignment of the teeth. Benefits are provided for Dependent children only up to the lifetime maximum reflected in the Schedule of Dental Benefits.

Dental Expenses That Are Not Covered

- Dental services provided purely for cosmetic reasons or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.
- Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth (such as equilibration and periodontal splinting).
- Replacement of more than one orthodontic appliance per Dependent child.
- Gold crowns or restorations in excess of the amount payable for amalgam restorations, except:
    - When used in teeth as bridge abutments; or
    - When required to restore a tooth to its proper contour and there is no other reasonable restoration available.
- Replacement of a prosthetic appliance if it is satisfactory or can be made satisfactory.

- Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.
- Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.
- Grafting tissues from outside the mouth to tissues inside the mouth (extraoral grafts).
- Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.

Vision Benefits

Vision benefits are treated as a standalone (or excepted) benefit under the Health Insurance Portability and Accountability Act (HIPAA) and the Patient Protection and Affordability Care Act of 2010 (PPACA). However, the Trustees have decided to allow vision coverage for Dependents up to age 26 even though it is not required to do so.

At Open Enrollment, you must choose which vision plan you wish to enroll in. If you do not choose a vision plan, VSP will become your assigned plan.

VSP Providers

Eye care is an important part of your overall health. You can save money on your vision expenses by using providers who are part of the Vision Service Plan (VSP). If you select a VSP provider, the Plan provides covered services at 100% after a $25 Copay. This Copay is payable to the VSP provider each time you receive services.

You will receive up to a $150 allowance for frames purchased at a VSP provider. You are covered for one frame in a 12-month period. Exams and lenses are covered in full once in a 12-month period after the Copay has been met.

Active employees may purchase an additional pair of glasses in a 12-month period for an additional $25 Copay. Dependents are not eligible for these additional frames.

Spectera Vision Providers

If you elect Spectera during Open Enrollment, you must use Spectera providers. The Plan provides covered services at 100% after a $10 Copay for each exam and a $10 Copay for materials. This Copay is payable to the Spectera provider each time you receive services.

You will receive up to a $130 allowance for frames and up to $105 for contact lenses purchased at a Spectera provider. You are covered for one frame in a 24-month period. Exams and lenses are covered in full once in a 12-month period after the Copay has been paid.

Active Employees may purchase an additional pair of glasses in a 12-month period for an additional $10 Copay. Dependents are not eligible for these additional frames.

Non-Contract Providers

If you choose to receive vision care from a Non-Contract Provider, you will be reimbursed for Covered Charges according to the schedule shown in your VSP or Spectera *Evidence of Coverage*. You will need to submit a claim along with an itemized statement of expenses to your vision plan. Please contact VSP, Spectera or the Trust Fund Office for a brochure if you do not have one available.

Covered Charges

The Plan is designed to cover visual rather than cosmetic needs. When you select any extras, your vision plan will pay the basic cost of the allowed lenses and you will be responsible for the additional costs. Please refer to your Evidence of Coverage from VSP or Spectera for a complete description of covered charges and expenses that are not covered by the vision plans.

Life, Dependent Life, And AD&D Benefits

Life Insurance benefits are not subject to the eligibility requirements of the Patient Protection and Affordability Care Act of 2010 (PPACA). However, the Trustees have decided to allow life insurance benefits for Dependents up to age 26 even though it is not required to do so.

Domestic Partners are not eligible for Life insurance benefits.

Life, dependent life, and accidental death and dismemberment (AD&D) benefits are funded directly from Plan assets.

Life and Dependent Life Benefits

In the event of your death, your beneficiary will receive a life benefit of $12,000.

If your eligible Dependent dies, you will be paid a benefit as follows:

Dependent	Amount Payable
Eligible Spouse	$1,500
Eligible Child Over Six Months of Age	$1,500
Eligible Child Under Six Months of Age	$ 150

Accidental Death and Dismemberment

Available For Employees Only (No Dependent Coverage)

Accidental death and dismemberment (AD&D) benefits are paid if you die or are seriously injured in an accident. You have $10,000 of AD&D coverage. The Plan pays all or a portion of that amount based on the type of loss.

Type Of Loss	Amount Payable
Life	$10,000
Both hands; Both feet; or Sight in both eyes	$10,000
One hand and one foot; One hand and sight of one eye; or One foot and sight of one eye	$10,000
One hand; or One foot; or Sight of one eye	$5,000

Benefits are payable only if a death or injury is a direct result of an accidental bodily injury sustained (work-related or non-work-related) while you are covered by the Plan. The loss must occur within 90 days after the date of the accident.

Benefits are paid directly to you for an injury or to your beneficiary for your death. AD&D benefits are in addition to any death benefits that may be paid. Only one benefit—the largest—is payable for more than one loss.

When AD&D Benefits Are Not Paid

Benefits are not paid for losses caused by:

- Suicide, attempted suicide or intentionally self-inflicted injury, while sane or insane;
- Bodily or mental infirmity, disease of any kind, or as a result of medical or surgical treatment;
- The individual's participation in a riot or the commission of or the attempt to commit a crime;
- War, whether declared or undeclared, or insurrection;
- Service, travel or flight in any species of aircraft, except as a fare-paying passenger in a licensed commercial aircraft operated on a regular schedule by a certified passenger carrier over its established air route.

Taxation of Life, Dependent Life, and AD&D Benefits

The proceeds payable upon receipt of a life, dependent life, or AD&D benefits will be taxable to the beneficiary.

Designating Your Beneficiary

You may name more than one beneficiary and you may change your beneficiary at any time. If you name more than one beneficiary, you should indicate how your benefits should be divided. The initial designation or change of designation will take effect on the date it is received by the Fund.

It's important that you name a beneficiary. If you don't name a beneficiary or if your beneficiary is not living at the time of your death, your benefit will be paid to your survivors as follows:

- Spouse; or if none,
- Children, in equal shares; or if none,
- Parent(s), in equal shares; or if none,
- Brothers and sisters, in equal shares; or if none,
- Estate.

Coordination of Benefits

The health care programs have been designed to help you meet the cost of sickness and/or injury. It is not intended, however, that you receive greater benefits than your actual health care expenses. The amount of medical and dental benefits payable under this Plan will be coordinated with any coverage you or a covered Dependent has under group or other government plans.

Specifically, in a calendar year, this Plan will always pay to you either its regular benefits in full or a reduced amount which, when added to the benefits payable to you by the other plan or plans, will equal the total "Allowed Charges." However, no more than the maximum benefits payable under this Plan will be paid.

Order of Payment

If you or your Dependent is covered under more than one plan, the primary plan pays first, regardless of the amount payable under any other plan. The other plan, the secondary plan, will adjust its benefit payment so that the total benefits payable does not exceed 100% of the Allowed Charges incurred.

If you or your Dependents are covered under another plan, you must report the other coverage when you file a claim.

The following rules determine which plan is the primary plan:

- A plan that does not have a coordination of benefits rule is always primary.
- A plan that covers an individual as an employee is primary.

The following rules determine which plan's benefits are primary if a Dependent child is covered under more than one plan:

- If the parents are married or living together (regardless of whether they have ever been married), the order of payment used to determine the primary plan is as follows:
  - The plan that covers the parent whose date of birth occurs earlier in the calendar year, excluding the year of birth, is primary.
  - If the birthday of both parents occurs on the same date, the plan that has covered the parent for the longer period of time is primary.
  - If a plan does not use the "birthday rule" to determine which plan pays first, the rules of that plan determine the order of benefit payments.
  - If none of the above apply, the plan covering the Dependent child the longest will be primary.
- If the parents are separated, divorced, or not living together (regardless of not living together), the order of payment used to determine the primary plan is as follows:
  - Where there is a court decree that states one of the parents has financial responsibility for health care expenses, the plan covering the Dependent child of the parent who has financial responsibility will pay first.
  - If there is a court decree that states both parents have financial responsibility for a Dependent child's health care expenses, the plan that covers the parent whose birthday occurs earlier in the calendar year will be primary; or if both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.
  - If there is a court decree establishing joint custody without specifying that one parent has responsibility for health care expenses, the plan covering the parent whose birthday falls first in

the calendar year is primary; or if both parents have the same birthday, the plan that has covered the parent for the longer period will be primary.

- Where there is no court decree, the plan of the:
  - Parent with custody is primary;
  - Stepparent married to the parent with custody of the child pays second;
  - Parent not having custody of the child pays third; and
  - The stepparent married to the parent without custody of the child pays fourth.
- For a Dependent child covered under this Plan and another plan through individuals who are not the parents of the child, the order of benefits shall be determined, as described below (the longer/shorter length of coverage), but if the length of coverage is the same under both plans, then the birthday rule (similar to the one described above) applies between the parents coverage and the Dependent's own coverage (e.g., provided through his or her employee) or coverage under a spouse's plan. For example, if a married Dependent child covered by this Plan is also covered as a dependent under the group health plan of his or her spouse, the plan that has covered the dependent for the longer period will pay primary. However, if the dependent has been covered under both plans for the same length of coverage, then the plan of the person whose birthday occurs earlier in the year will pay primary – either the employee-parent covering the dependent or the employee-spouse covering the dependent.

If the Plan makes payments it is not required to pay, it may recover and collect those payments from you, your Dependents, or any organization or insurance company that should have made the payment.

Coordination of Benefits with Medicare

Traditional Medicare is a two-part program. The first part is officially called "Hospital Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part A of Medicare. The second part is officially called "Supplementary Medical Insurance Benefits for the Aged and Disabled," and is commonly referred to as Part B of Medicare. Part A of Medicare primarily covers hospital benefits, although it also provides other benefits. Part B of Medicare primarily covers Physician services, although it, too, covers a number of other items and services.

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker, Dependent widow, or have chronic end-stage renal disease (ESRD). You should be aware that even if you do not choose to retire and do not begin receiving Social Security monthly payments at age 65, you are eligible to apply for both Parts A and B of Medicare. Since Part A of Medicare is usually free, you should apply for it as soon as you are eligible. You will be required to pay a monthly premium for Part B of Medicare.

If you or a Dependent are entitled to (eligible for and enrolled in), this Plan will generally pay secondary to Medicare for as long as you remain an Active Employee.

Information Gathering

In order to implement the provisions in this coordination of benefits section, the Trustees or the Administrator may, without the consent of, or notice to, any person, release or obtain any information which the Plan deems necessary for such purposes. Any person claiming benefits under this Plan will provide to the Trustees or to the Administrator such information as may be necessary to implement the provisions of this section or to determine their applicability.

Claims For Benefits

Filing Claims

Filing a claim is easy if you follow the steps described in this section. If a claim is denied or reduced, there is a process you can follow to have your self-funded claim reviewed by the Trustees. **Note that if you are in an insured HMO or Pre-Paid Dental Plan offered by the Fund, the Trustees have no authority to hear your appeal of a denied claim under those plans except for issues related to eligibility.**

Fee-For-Service Medical Claims

Most health care providers (i.e., Physician, hospital, and vision care providers) will submit your claims for you. Be sure to show your ID card so your Physician or hospital will know where to submit your claim. If your provider does not submit your claim for you, it is your responsibility to do so.

If you or a Dependent has coverage under more than one health care plan, benefits are coordinated as explained in the **Coordination of Benefits** section.

If you are enrolled in a medical HMO or prepaid dental plan, you generally do not need to fill out claim forms.

All claims must be submitted within 90 days after you receive a bill for services or supplies. Claims will not be paid if they are submitted more than one year from the date on which the services were received.

To assist in processing claims as quickly as possible, please be sure to include the information below:

- Your Social Security Number and signature. If the claim is for a Dependent, provide the name and date of birth of the Dependent.
- If you or a Dependent has coverage under more than one health plan, be sure to include the name of the other health plan(s).
- Have your health care provider complete any portion of the claim form that requests his or her information.
- Provide all bills or receipts relating to the service provided.
  - Make sure each bill clearly identifies the service or supply, the fee, the patient's name, and the date of service.
  - If Medicare also covers you, attach a copy of the itemized bill relating to the health service provided and a copy of Medicare's explanation of benefits. Both the bill and Medicare's explanation of benefits must be submitted.
- Forward the completed form and all related bills to the Trust Fund Office.

Fee-For-Service Dental Claims

Your Fee-For-Service Dental Plan strongly recommends that a pre-determination of benefits be obtained for charges of $200 or more and for any orthodontic treatment plan for a Dependent child. Be sure to advise your dentist of this requirement. For pre-determination, your dentist should contact Delta Dental at 800-422-4234.

All claims must be submitted within 90 days after you receive a bill for services or supplies. Claims will not be paid if they are submitted more than one year from the date on which the services were received. You dentist may submit claims on your behalf.

If you are submitting a claim, please follow the steps listed below.

- Complete and sign your claim form.
- Have your dentist complete his or her portion of the claim form.
- Submit the form to Delta Dental for processing.

Life, Dependent Life, And AD&D Claims

In the event of your death, your beneficiary should call the Trust Fund Office for help in filing a claim. If you have an injury covered under the AD&D program, you should file a claim. In the event of the death of your Dependent spouse or child, you should contact the Trust Fund Office about how to file a claim. The Plan requires proof of death or loss—usually in the form of a death certificate or Physician's statement. In some situations, the Plan has the right to request a physical exam by a Physician of its choice or an autopsy. Proof of death or loss must be submitted within 90 days, or as soon as reasonably possible when, in the Board of Trustees' sole discretion, it is found to have not been reasonably possible to file the claim within such time. **In no case will a Life and AD&D claim be paid if the claim is submitted more than one year after the loss is incurred.**

Internal Claims and Appeal Procedures

This section describes the procedures followed by the California Ironworkers Field Welfare Plan in making internal claim decisions and reviewing appeals of denied claims. These procedures apply to claims for medical, mental health, substance abuse, employee assistance program (EAP), self-funded dental, vision, hearing, wellness (i.e., the Reinforcing Smart Choices Program) and prescription drugs. The claims and appeal procedures for life, accidental death and dismemberment and fully insured dental benefits are described in the insurance company's policy.

The Plan's internal claims and appeal procedures are designed to provide you with full, fair, and fast claim review and so that Plan provisions are applied consistently with respect to you and other similarly situated participants and dependents. In addition, the Plan must 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 or appropriate, or is Experimental or Investigational).

The internal claims process pertains to determinations made by the appropriate Claims Administrator about whether a request for benefits (known as an initial "claim") is payable. If the appropriate Claims Administrator denies your initial claim for benefits (known as an "adverse benefit determination"), you have the right to appeal the denied claim under the Plan's internal appeals process.

For certain health benefit claims, you may seek an external review with an Independent Review Organization (IRO) that conducts reviews of adverse benefit determinations either (i) after the Plan's internal appeals process has been exhausted, or (ii) under limited circumstances before the Plan's internal claims and appeals process have been exhausted.

General Information

Claims Administrator(s)

The Plan Administrator has delegated responsibility for initial claims decisions to the following companies/organizations:

Appropriate Claims Administrator	Types of Claims Processed

Appropriate Claims Administrator	Types of Claims Processed
Anthem Blue Cross of California	• Medical Post-Service Claims
Anthem Blue Cross of California Pacific Health Alliance (PHA)	• Medical Urgent, Concurrent and Pre-service Medical Claims • Medical Urgent, Concurrent and Pre-service Medical Claims (Outpatient Surgeries and Certain Procedures (see page 24 for more information))
Managed Health Network (MHN)	• Pre-Service Claims for EAP visits • Mental Health Urgent, Concurrent, Pre-Service, and Post-Service Claims
Managed Health Network (MHN)	• Pre-Service Claims for EAP visits • Substance Abuse Urgent, Concurrent, Pre-Service, and Post-Service Claims
EnvisionRx Options	• Prescription Drug Pre-service Claims • Prescription Drug Post-Service Claims for non-contract pharmacy retail drugs
Plan Administrator California Ironworkers Field Welfare Plan 131 N. El Molino Avenue Ste. 330 Pasadena, CA 91101-1878 626-792-7337 or 800-527-4613 ironworkerbenny.com	• Wellness Post-Service Claims
Delta Dental	• Dental Post-Service Claims
Vision Service Plan Spectera Vision Plan	• Vision Post-Service Claims
Life Insurance, Dependent Life Insurance, and Accidental Death and Dismemberment	• Life Insurance/Death Benefit Claims • Dependent Life Insurance Claims • Accidental Death and Dismemberment Claims

Days Defined

For the purpose of the initial claims and appeal processes, “days” refers to calendar days, not business days.

Discretionary Authority Of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Plan Administrator, other Plan fiduciaries, Claims Administrators, and other individuals to whom responsibility for the administration of the Plan has been delegated, have discretionary authority to interpret the terms of the Plan and to interpret any facts relevant to the determination, 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.

Adverse Benefit Determination

- An adverse benefit determination, for the purpose of the internal claims and appeal process for a health benefit claim, means:

- A denial, reduction, or termination of, or a failure to provide or make payment in whole or in part for a benefit, including a determination of an individual's eligibility to participate in the Plan or a determination that a benefit is not a covered benefit;
- A reduction of a benefit resulting from the application of any utilization review decision, source-of-injury exclusion, network exclusion, or other limitation on an otherwise covered benefit or failure to cover an item or service for which benefits are otherwise provided because it is determined to be not Medically Necessary or appropriate, or Experimental or Investigational; or
- A rescission of coverage, whether or not there is an adverse effect on any particular benefit.

Health Care Professional

A health care professional, for the purposes of the claims and appeals provisions, means a Physician or other health care professional licensed, accredited or certified to perform specified health services consistent with state law.

Culturally and Linguistically Appropriate Notices

All notices relating to Health Benefit Claims will contain a notice about the availability of Spanish, Chinese, Tagalog or Navajo language services. Assistance with filing a claim for Health Benefits in Spanish, Chinese, Tagalog, or Navajo is available by calling (800) 527-4613. Notices relating to Health Benefit Claims will be provided in Spanish, Chinese, Tagalog, or Navajo upon request.

SPANISH (Español): Para obtener asistencia en Español, llame al (800) 527-4613.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa (800) 527-4613
CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (800) 527-4613
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (800) 527-4613

Definition of a Claim

A claim is a request for a Plan benefit made by you or your covered Dependent (also referred to as "claimant") or your authorized representative in accordance with the Plan's reasonable claims procedures.

Types of Claims

Health Benefit Claims

Health benefit claims can be filed for medical, mental health, substance abuse, EAP, dental, vision, wellness, and prescription drug benefits.

There are four categories of health claims as described below:

- ***Pre-Service Claims*** **(applicable to medical, mental health, substance abuse, prescription drug benefits or a predetermination of benefits under the self-funded dental plan)** - A Pre-Service Claim is a claim for a benefit that requires approval of the benefit (in whole or in part) before health care is obtained. Under this Plan, prior approval is required for some medical, mental health, substance abuse, and prescription drug benefits.
- ***Urgent Care Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)** – An Urgent Care Claim is any Pre-Service Claim for health care treatment that (i) could seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or (ii) in the opinion of the claimant's attending health care provider with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. However, the Plan will not deny benefits for these procedures or services if it is not possible for the claimant to

obtain the pre-approval, or the pre-approval process would jeopardize the claimant's life or health.

- ***Concurrent Claims*** **(applicable to medical, mental health, substance abuse, and prescription drug benefits)** - A Concurrent Claim is a claim that is reconsidered after an initial approval has been made and results in a reduced or terminated benefit. Also, a Concurrent Claim can pertain to a request for an extension of a previously approved treatment or service.
- ***Post-Service Claims*** **(applicable to medical, mental health, substance abuse, EAP, self-funded dental, vision, wellness, and prescription drug benefits)** - A Post-Service Claim is a request for benefits under the Plan that is not a Pre-Service Claim. Post-Service Claims are requests that involve only the payment or reimbursement of the cost of the care that has already been provided. A standard paper claim or electronic bill submitted for payment after services have been provided are examples of a Post-Service Claim. A claim regarding the rescission of coverage will be considered to be a Post-Service Claim.

Claim Elements

An initial claim must include the following elements to trigger the Plan's internal claims process:

- Be written or electronically submitted (oral communication is acceptable only for Urgent Care Claims);
- Be received by the Plan Administrator or Claims Administrator (as applicable);
- Name a specific individual participant, his/her Social Security Number and Member ID;
- Name a specific claimant and his/her date of birth;
- Name a specific medical condition or symptom;
- Provide a description and date of a specific treatment, service or product for which approval or payment is requested (must include an itemized detail of charges);
- Identify the provider's name, address, phone number, professional degree or license, and federal tax identification number (TIN); and
- When another plan is primary payer, include a copy of the other Plan's Explanation of Benefits (EOB) statement along with the submitted claim.

A request is *not* a claim if it is:

- Not made in accordance with the Plan's benefit claims filing procedures described in this section;
- Made by someone other than you, your covered dependent, or your (or your covered dependent's) authorized representative;
- Made by a person who will not identify himself or herself (anonymous);
- 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;
- A request for prior approval where prior approval is not required by the Plan;
- An eligibility inquiry that does not request 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;
- The presentation of a prescription to a retail pharmacy or mail order pharmacy that the pharmacy denies at the point of sale. After the denial by the pharmacy, you may file a claim with the Plan;

- A request for an eye exam, lenses, frames or contact lenses that is denied at the point of sale from the Plan's contracted in-network vision provider(s). After the denial by the vision service provider, you may file a claim with the Plan.

If you submit a claim that is not complete or lacks required supporting documents, the Plan Administrator or Claims Administrator, as applicable, will notify you about what information is necessary to complete the claim. This does not apply to simple inquiries about the Plan's provisions that are unrelated to any specific benefit claim or which relate to proposed or anticipated treatment or services that do not require prior approval, which are not considered claims.

Initial Claim Decision Timeframes

Claim Filing Deadline

Claims must be filed within twelve (12) months following the date charges were incurred. Failure to file claims within the time required will not invalidate or reduce any claim, if in the Board of Trustees' sole discretion it is found to have not been reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than eighteen (18) months from the date the charges were incurred.

The time period for making a decision on an initial claim request starts as soon as the claim is received by the appropriate Claims Administrator, provided it is filed in accordance with the Plan's filing procedures, regardless of whether the Plan has all of the information necessary to decide the claim. A claim may be filed by you, your covered dependent, an authorized representative, or by a network provider. In the event a claim is filed by a provider, the provider will not automatically be considered to be your authorized representative.

Health Care Claims – Decision Timeframes

The Plan will provide you, automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which notice of an adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the new or additional rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

- **<u>Pre-Service Claims</u> (applicable to medical, mental health, substance abuse, and prescription drug benefits and a dental predetermination of benefits on the self-funded dental plan)**

  Claims for Pre-Service (that are not for Urgent Care) will be decided no later than fifteen (15) days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the initial fifteen (15) day period whether the claim was approved or denied (in whole or in part).

  The time for deciding the claim may be extended by the Claims Administrator by up to fifteen (15) days due to circumstances beyond the Claims Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, if a applicable) notification before the expiration of the initial fifteen (15) day determination period.

  If you improperly file a Pre-Service Claim, the Claims Administrator will notify you in writing (or

electronically, as applicable) as soon as possible, but in no event later than five (5) days after receiving the claim. The notice will describe the proper procedures for filing a Pre-Service Claim. Thereafter, you must re-file a claim to begin the Pre-Service Claim determination process.

If a claim cannot be processed due to insufficient information, the Claims Administrator will notify you in writing (or electronically, as applicable) about what specific information is needed before the expiration of the initial fifteen (15) day determination period. Thereafter, you will have 45 days following the date the notice is issued to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination). During the period in which you are permitted to supply additional information, the normal period for making a decision is suspended. The claim decision deadline is suspended until the earlier of 45 days from either 1) the date the notice is issued; or 2) the date the Claims Administrator receives your response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

The Claims 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.

- **<u>Urgent Care Claims</u> (applicable to medical, mental health, substance abuse, and prescription drug benefits)**

  In the case of an Urgent Care Claim, if a health care professional with knowledge of your medical condition determines that a claim constitutes an Urgent Care Claim, the health care professional will be considered by the Plan to be your authorized representative, bypassing the need for completion of the Plan's written authorized representative form.

  The appropriate Claims Administrator will decide claims for Urgent Care as soon as possible, but in no event later than 72 hours after receipt of the claim. The Claims Administrator will orally communicate its decision telephonically to you. The determination will also be confirmed in writing (or electronically, as applicable) no later than three (3) days after the oral notification.

  If you improperly file an Urgent Care Claim, the Claims Administrator will notify you as soon as possible, but in no event later than 24 hours after receiving the claim. The written (or electronic, as applicable) notice will describe the proper procedures for filing an Urgent Care Claim. Thereafter, you must re-file a claim to begin the Urgent Care Claim determination process.

  If a claim cannot be processed due to insufficient information, the Claims Administrator will provide you with a written (or electronic, as applicable) notification about what specific information is needed as soon as possible and no later than 24 hours after receipt of the claim. Thereafter, you will have not less than 48 hours following receipt of the notice to supply the additional information. If you do not provide the information during the period, the claim will be denied (i.e., an adverse benefit determination will be made). Written (or electronic, as applicable) notice of the decision will be provided to you no later than 48 hours after the Claims Administrator receives the specific information or the end or the period given for you to provide this information, whichever is earlier.

- **<u>Concurrent Claims</u> (applicable to medical, mental health, substance abuse, and prescription drug benefits)**

  If a decision is made to reduce or terminate an approved course of treatment, you will be provided

with a written (or electronic, as applicable) notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to request an appeal and obtain a determination of that adverse benefit determination before the benefit is reduced or terminated.

A Concurrent Claim that is an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes described above under the Urgent Care Claim section.

A Concurrent Claim that is not an Urgent Care Claim will be processed according to the Plan's internal appeals procedures and timeframes applicable to the Pre-Service or Post-Service Claim, as applicable, provisions described above in this section.

If the Concurrent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

If the Concurrent Care Claim is denied, in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice.

- **Post-Service Claims (applicable to medical, mental health, substance abuse, EAP, self-funded dental, vision, wellness, and prescription drug claims)**

  Claims for Post-Service treatments or services will be decided no later than 30 days after receipt by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is denied (in whole or in part).

  The time for deciding the claim may be extended by the Claim Administrator by fifteen (15) days due to circumstances beyond the Claim Administrator's control (e.g., inability of a medical reviewer to meet a deadline); provided you are given written (or electronic, as applicable) notification before the expiration of the initial 30-day determination period.

  If a claim cannot be processed due to insufficient information, the Claim Administrator will notify you in writing (or electronically, as applicable) about what information is needed before the expiration of the initial 30-day determination period. Thereafter, you will have 45 days after your receipt of the notice to supply the additional information. If you do not provide the information during the 45-day period, the claim will be denied (i.e., an adverse benefit determination will be made). During the period in which you are permitted to supply additional information, the normal period for making a decision on the claim is suspended. The claim decision deadline is suspended until the earlier of 45 days or until the date the Claims Administrator receives your written response to the request for information. The Claims Administrator then has fifteen (15) days to make a decision and notify you in writing (or electronically, as applicable).

Initial Determinations of Health Benefit Claims

Notice of Adverse Benefit Determination of Health Benefit Claims

If the Claims Administrator denies your initial claim, in whole or in part, you will be given a notice about the denial (known as a "notice of adverse benefit determination"). The notice of adverse benefit determination will be given to you in writing (or electronically, as applicable) within the timeframe required to make a decision on a particular type of claim. The notice of adverse determination must:

- Identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, denial code and its corresponding meaning);

  Give the specific reason(s) for the denial (including a statement that the claimant has the right to request the applicable diagnosis and treatment code and their corresponding meanings; however such

a request is not considered to be a request for an internal appeal or external review);

- If the denial is based on a Plan standard that was used in denying the claim, a description of such standard.
- Reference the specific Plan provision(s) on which the denial is based;
- Contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- 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 internal appeal and external review processes along with time limits and information about how to initiate an appeal and an external review;
- Contain a statement that you have the right to bring civil action under ERISA section 502(a) following an appeal;
- If the denial was based on an internal rule, guideline, protocol or similar criteria, a statement will be provided that such rule, guideline, protocol or similar criteria that was relied upon will provided to you free-of-charge 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 to you free-of-charge upon request;
- For Urgent Care Claims, the notice will describe the expedited internal appeal and external review processes applicable to Urgent Care Claims. In addition, the required determination may be provided orally and followed with written (or electronic, as applicable) notification; and
- Provide information about the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with the Plan's internal claims and appeal processes as well as with the external review process.

Notice of Approval of Pre-Service and Urgent Care Health Benefit Claims

If a Pre-Service claim is approved, the Claim's administer will provide written (or electronic, as applicable) notice within fifteen (15) days of the appropriate Claims Administrator's receipt of the claim. Notice of Approval of an Urgent Care Claim will be provided not later than 72 hours after receipt of the claim. This notice will be provided orally, followed by written (or electronic, as applicable) confirmation of this notice provided no later than three (3) calendar days after the oral notice.

Notice of Approval of Post-Service and Concurrent Health Benefit Claims

Claims for Post-Service treatments or services will be decided no later than 30 days after receipt of the claim by the appropriate Claims Administrator. You will be notified in writing (or electronically, as applicable) within the 30-day initial determination period if the claim is approved.

If a Concurrent Claim that is not an Urgent Care Claim is approved you will be notified orally followed by written (or electronic, as applicable) notice provided no later than three (3) calendar days after the oral notice.

All notices relating to a Health Benefit Claim will contain a notice about the availability of Spanish, Chinese, Tagalog, and Navajo language services. Assistance with filing a Health Benefit Claim in Spanish, Chinese, Tagalog or Navajo is available by calling (800) 527-4613. Notices relating to Health Benefit Claims will be provided in Spanish, Chinese, Tagalog, or Navajo upon request.

Internal Appeal Request Deadline

- ***Health Benefit Claims*** **(applicable to medical, mental health, substance abuse, EAP, self-funded dental, vision, wellness, and prescription drug benefits)**

- If an initial health care claim is denied (in whole or in part) and you disagree with the Claims Administrator's decision, you or your authorized representative may request an internal appeal. You have 180 calendar days following receipt of a notice of adverse benefit determination to submit a written request for an internal appeal. The Plan will not accept appeals filed after this 180-day period. Under limited circumstances, explained below in the section on External Review, you may bypass the Plan's internal claims and/or appeal processes and file a request for an external review.

Internal Appeals Process

Appeal Procedures

To file an internal appeal, you must submit a written statement to the Plan at the following address:

Plan Administrator
California Ironworkers Field
Welfare Plan
131 N. El Molino Avenue
Ste. 330
Pasadena, CA 91101-1878
626-792-7337 or 800-527-4613
ironworkerbenny.com

Your request for an internal appeal must include the specific reason(s) why you believe the initial claim denial was improper. You may submit any document that you feel is appropriate to the internal appeal determination, as well as submitting any written issues and comments.

Additional Appeal Procedures for Health Benefit Claims

Appeal requests involving Urgent Care Claims may be made orally by calling the Fund Office at the telephone number listed above.

As a part of its internal appeals process, the Plan will provide you with:

- Upon request and without charge, reasonable access to and copies of all documents, records and other information relevant to your initial claim for benefits;
- The opportunity to submit to the Plan written comments, documents, records and other information relating to your initial claim for benefits;
- A full and fair review by the Plan 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 claim determination;
- The Plan will provide you automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an adverse benefit determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the new or additional rationale. The rationale will be

provided as soon as possible (and sufficiently in advance of the date on which the notice of adverse benefit determination on review is required to be provided) to give you a reasonable time to respond prior to that date.

- A review that does not afford deference to the initial adverse benefit determination and that is conducted by an appropriate fiduciary or fiduciaries of the Plan who is neither the individual who made the initial 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, Medically Necessary or appropriate, the fiduciary or fiduciaries will:

  Consult with a health care professional who 1) has appropriate experience in the field of medicine involved in the medical judgment; and 2) is neither an individual who was consulted in connection with the initial 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 the adverse benefit determination without regard to whether the advice was relied upon in making the benefit determination.
- Participants and beneficiaries may request documents and plan instruments regarding whether the plan is providing benefits in accordance with Mental Health Parity and Addiction Equity Act (MHPAEA) and copies must be furnished within 30 days of a request. This may include documentation that illustrates how the health plan has determined that any financial requirement, quantitative treatment limitation, or non-quantitative treatment limitation is in compliance with MHPAEA.

Appeal Determination Timeframes

Health Benefit Claims

- ***Pre-Service Claims (applicable to medical, mental health, substance abuse, a self-funded dental preauthorization for benefits and prescription drug benefits).*** A determination will be made and a written (or electronic, as applicable) notice regarding the appeal will be sent to you within 30 days from the date your written request for an appeal is received by the Plan. No extension of the Plan's internal appeal review timeframe is permitted.

- ***Urgent Care Claims (applicable to medical, mental health, substance abuse, and prescription drug benefits).*** This is an expedited internal appeals process under which a written notice regarding a decision on the approval or denial of the expedited internal appeal will be sent to you (and your health care professional) no later than within 72 hours of the Plan's receipt of your (oral or written) request for appeal. If your situation involves an urgent medical condition, which the timeframe for completing an expedited internal appeal would seriously jeopardize your ability to regain maximum function, and the claim involves a medical judgment or a rescission of coverage, you may seek an expedited external review at the same time that you request an expedited internal appeal (you must seek both at this time or else forfeit your opportunity for external review).

- **Concurrent Claims** ***(applicable to medical, mental health, substance abuse, and prescription drug benefits).*** You may request an internal appeal of a Concurrent Claim by submitting the request orally (for an Urgent Care Claim) or in writing to the Plan Administrator. A determination will be made on the internal appeal and you will be notified as soon as possible before the benefit is reduced or treatment is terminated.

- **Post-Service Claims *(applicable to medical, mental health, substance abuse, EAP, self-funded dental, vision, wellness, and prescription drug benefits).*** The Plan will make an appeal determination no later than the date of the Board of Trustees' meeting immediately following the Plan's receipt of your written request for an internal appeal, unless the request for an internal appeal review is filed within 30 calendar days preceding the date of such meeting. In such case, an appeal determination will be made no later than the date of the second meeting following the Plan's receipt of your written request for an appeal. If special circumstances (such as the need to hold a hearing) require a further extension of time for processing, an appeal determination will be rendered not later than the third meeting following the Plan's receipt of your written request for review. If such an extension is necessary, the Plan will provide you with a written (or electronic, as applicable) notice of extension describing the special circumstances and date the appeal determination will be made. The Plan Administrator will notify you in writing (or electronically, as applicable) of the benefit determination no later than five (5) calendar days after the benefit determination is made.

Notice of Adverse Benefit Determination Upon Appeal

A written (or electronic, as applicable) notice of the appeal determination must be provided to you that includes:

- The specific reason(s) for the adverse benefit determination upon appeal, including (i) the denial code (if any) and its corresponding meaning, (ii) a description of the Plan's standard (if any) that was used in denying the claim, and (iii) a discussion of the decision;
- Reference the specific Plan provision(s) on which the denial 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;
- An explanation of the external review process, along with any time limits and information about how to initiate a request for an external review;
- If the denial was based on an internal rule, guideline, protocol or similar criterion a statement must be provided that such rule, guideline, protocol or criteria will be provided free of charge, upon request;
- If the denial was based on a medical judgment (Medical Necessity, Experimental or Investigational), a statement must be provided that an explanation regarding the scientific or clinical judgment for the denial will be provided free of charge, upon request; and
- Disclosure of the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist you with internal claims and appeals and external review processes.

This concludes the appeal process under this Plan. The Plan does not offer a voluntary internal appeal process.

Culturally and Linguistically Appropriate Notices

All notices relating to an Internal Appeal of a Health Benefit Claim will contain a notice about the availability of Spanish, Chinese, Tagalog, and Navajo language services. Assistance with filing an internal appeal in Spanish, Chinese, Tagalog, or Navajo is available by calling (800) 527-4613. Notices relating to internal appeal will be provided in Spanish, Chinese, Tagalog, or Navajo upon request.

Authorized Representative

The 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 an initial claim and appeal an adverse benefit determination under the Plan An authorized representative under the Plan also includes a health care professional. You do not need to designate in writing that the health care professional is your authorized representative if that health care professional is part of the claim appeal. A health care provider with knowledge of your medical condition may act as your authorized representative in connection with an Urgent Care Claim without filing a written statement with the Plan.

The Plan requires you to provide a written statement declaring your designation of an authorized representative along with the representative's name, address, phone number, and email address. To designate an authorized representative, you must submit a completed authorized representative form (available from the Fund Office).

If you are 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 your 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 rather than to you. The Plan will honor the designated authorized representative until the designation is revoked, or as mandated by a court order. You may revoke a designated authorized representative status by submitting a completed change of authorized representative form available from and to be returned to the Fund 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.

Limitation On When A Lawsuit May Be Started

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before administrative agencies, until after all administrative procedures have been exhausted (including this Plan's internal claims and appeal procedures described in this section) for every issue deemed relevant by the claimant, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. The law also permits you to pursue your remedies under section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly.

In addition, you are not required to exhaust external review before seeking judicial remedy.

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

Elimination of Conflict of Interest

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

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, Plan Administrator, Board of Trustees, other Fiduciary, or appropriate Claims Administrator nor any other designee of the Plan will be required to see to the application of the money so paid.

Except to the extent noted above or elsewhere in this document, you or your beneficiary is restrained from selling, transferring, anticipating or otherwise disposing of any benefit payable hereunder, or any other right or interest under the Plan, and the Plan shall not be required to recognize any such sale, transfer, anticipation, assignment, or other disposition. Any such benefit, right or interest shall not be subject in any manner to voluntary transfer by operation of law or otherwise.

You or your beneficiary may direct that benefits due be paid to a provider of covered services or supplies in consideration for services rendered or supplies furnished, or to any other agency that may have provided or paid for benefits provided under this Plan. **[Note: Language is from the Rules and Regulations document, dated January 1, 2002.]**

External Review Of Claims

If your initial claim for health care benefits has been denied (i.e., an adverse benefit determination) in whole or in part, and you are dissatisfied with the outcome of the Plan's internal claims and appeals process described earlier, you may (under certain circumstances) be able to seek external review of your claim by an Independent Review Organization ("IRO"). This process provides an independent and unbiased review of eligible claims in compliance with the Affordable Care Act.

Culturally And Linguistically Appropriate Notices

All notices relating to external review sent will contain a notice about the availability of Spanish, Chinese, Tagalog, Navajo, as applicable language services. Assistance with filing a claim for external review in Spanish, Chinese, Tagalog, Navajo, as applicable is available by calling the Fund Office.

Health Benefit Claims Eligible For The External Review Process

Post-Service, Pre-Service, Urgent Care, and Concurrent Care Health Benefit Claims, in any dollar amount, are eligible for external review by an IRO if:

- The adverse benefit determination of the claim involves a medical judgment, including but not limited to, those based on the Plan's requirements for Medical Necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, denial related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or Investigational. The IRO will determine whether a denial involves a medical judgment.
- The denial is due to a rescission of coverage (i.e., the retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.

Claims Not Eligible For The External Review Process

The following types of claims are not eligible for the external review process:

- Claims that involve only contractual or legal interpretation without any use of medical judgment.

- A determination that you or your dependent are not eligible for coverage under the terms of the Plan.
- Claims that are untimely, meaning you did not request review within the four (4) month deadline for requesting external review.
- Claims as to which the Plan's internal claims and appeals procedure has not been exhausted (unless a limited exception applies).
- Claims that relate to benefits other than health care benefits (such as life, dependent life, and accidental death and dismemberment benefits, (as well as dental and vision benefits that are considered excepted benefits)).

Claims that relate to benefits that the Plan provides through insurance. Claims that relate to benefits provided through insurance are subject to the insurance company's external review process, not this process.

In general, you may only seek external review after you receive a "final" adverse benefit determination under the Plan's internal appeals process. A "final" adverse benefit determination means the Plan has continued to deny your initial claim in whole or part and you have exhausted the Plan's internal claims and appeals process.

Under limited circumstances, you may be able to seek external review before the internal claims and appeals process has been completed:

- If the Plan waives the requirement that you complete its internal claims and appeals process first.
- In an urgent care situation (see "Expediated External Review Of An Urgent Care Claim"). Generally, an urgent care situation is one in which your health may be in serious jeopardy or, in the opinion of your health care professional, you may experience pain that cannot be adequately controlled while you wait for a decision on your internal appeal.
- If the Plan has not followed its own internal claims and appeals process and the failure was more than a minor error. In this situation, the internal claims and appeal is "deemed exhausted," and you may proceed to external review. If you think that this situation exists, and the Plan disagrees, you may request that the Plan explain in writing why you are not entitled to seek external review at this time.

External Review Of A Standard (Non-Urgent Care) Claim

Your request for external review of a standard (not Urgent Care) claim must made in writing within four (4) months after you receive notice of an adverse benefit determination.

Because the Plan's internal claims and appeals process generally must be exhausted before external review is available, external review of standard claims will ordinarily only be available after you receive a "final" adverse benefit determination following the exhaustion of the Plan's internal claims and appeals process.

To begin the standard external review process, do the following:

Plan Administrator
California Ironworkers Field
Welfare Plan
131 N. El Molino Avenue
Ste. 330
Pasadena, CA 91101-1878
626-792-7337 or 800-527-4613
ironworkerbenny.com

Preliminary Review Of A Standard (Non-Urgent Care) Claim By The Plan

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

- You are/were covered under the Plan at the time the health care item or service is/was requested; or, in the case of a retrospective review, you were covered at the time the health care item or service was provided.
- The adverse benefit determination satisfies the above-stated requirements for a claim eligible for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination, or a failure to pay premiums causing a retroactive cancellation of coverage.
- You have exhausted the Plan's internal claims and appeals process (or a limited exception allows you to proceed to external review before that process is completed).
- Your request is complete, meaning that you have provided all of the information or materials required to process an external review.

Within one (1) business day of completing its preliminary review, the Plan will notify you in writing whether:

- Your request is complete and eligible for external review.
- Your request is complete but not eligible for external review. (In this situation, the notice will explain why external review is not available, and provide contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272).)
- Your request is incomplete. (In this situation, the notice will describe the information or materials needed to make the request complete. You must provide the necessary information or materials within the four (4) month filing period, or, if later, within 48 hours after you receive notification that your request is not complete.)

Review Of A Standard (Not Urgent Care) Claim By The IRO

If your request is complete and eligible for external review, the Plan will assign it to an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and it rotates assignments among these IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

Once the claim has been assigned to an IRO, the following procedures apply:

- The IRO will timely notify you in writing that your request is accepted for external review.
- The IRO will explain how you may submit additional information regarding your claim if you wish. In general, you must provide additional information within ten (10) business days. The IRO is not required to, but may, accept and consider additional information you submit after the ten (10) business day deadline.
- Within five (5) business days after the claim has been assigned to the IRO, the Plan will provide the IRO with the documents and information it considered in making its adverse benefit determination.
- If you submit additional information to the IRO related to your claim, the IRO must forward that information to the Plan within one (1) business day. Upon receipt of any such information (or at any other time), the Plan may reconsider its adverse benefit determination regarding the claim that is the subject of the external review. Any reconsideration by the Plan will not delay the external review. If Plan reverses its determination after it has been assigned to an IRO, the Plan will provide written

notice of its decision to you and the IRO within one (1) business day. Upon receipt of such notice, the IRO will terminate its external review.

- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo,* meaning that the IRO is not bound by the Plan's previous internal claims and appeal decisions. However, the IRO must review the Plan's terms to ensure that its decision is not contrary to the terms of the Plan, unless those terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.
- To the extent additional information or materials are available and appropriate, the assigned IRO may consider the additional information including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- In a standard case, the IRO will provide written notice of its final decision to you and the Plan within 45 days after the IRO receives the request for the external review.

The IRO's decision notice will contain:

- A general description of the reason(s) for the request for external review, including information sufficient to identify the claim, including the date or dates of service, the health care provider, the claim amount (if applicable), and the reason for the previous denial.
- The date that the IRO received the assignment to conduct the external review and the date of the IRO decision.
- References to the evidence or documents, including the specific coverage provisions and evidence-based standards, considered in reaching its decision.
- A discussion of the principal reason(s) for the decision, including the rationale for the decision and any evidence-based standards relied upon.
- A statement that the IRO's decision is binding on you and the Plan, except to the extent that other remedies may be available to you or the Plan under applicable state or federal law.
- A statement that judicial review may be available to you.
- A statement regarding assistance that may be available to you from an applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act.

Expedited External Review Of An Urgent Care Claim

You may request an expedited external review in the following situations if:

- You receive an adverse benefit determination regarding your initial claim that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal.
- You receive a "final" adverse benefit determination after exhausting the Plan's internal appeals procedure that (i) involves a medical condition for which the timeframe for completion of an standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function; or (ii) concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, and you have not yet been

discharged from a facility.

To begin a request for expedited external review, do the following:

Plan Administrator
California Ironworkers Field
Welfare Plan
131 N. El Molino Avenue
Ste. 330
Pasadena, CA 91101-1878
626-792-7337 or 800-527-4613
ironworkerbenny.com

Preliminary Review Of An Urgent Care Claim By The Plan

Immediately upon receipt of a request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described above for the standard claim external review process). The Plan will defer to your attending health care professional's determination that a claim constitutes "urgent care." The Plan will immediately notify you (e.g., telephonically, via fax) whether your request for review meets the requirements for expedited review, and if not, it will provide or seek the information described above for the standard claim external review process.

Review Of An Urgent Care Claim By The IRO

Upon a determination that a request is complete and eligible for an expedited external review following the preliminary review, the Plan will assign an accredited IRO. The Plan has arranged for at least three (3) accredited IROs to provide external review of claims, and rotates assignments among those IROs. In addition, the IRO may not be eligible for any financial incentives based on the likelihood that the IRO will support the denial of claims.

The Plan will expeditiously provide or transmit to the IRO all necessary documents and information that it considered in making its internal adverse benefit determination.

The IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the IRO must review the claim *de novo* meaning that it is not bound by any previous decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO decision must not be contrary to the terms of the plan, unless the terms are inconsistent with applicable law. For example, the IRO must observe all of the Plan's standards, including standards for clinical review, Medical Necessity, appropriateness, health care setting, level of care, and effectiveness of a covered benefit.

The IRO will provide notice of the final external review decision, in accordance with the requirements set forth above for the standard claim external review process, as expeditiously as your medical condition or circumstances require, but not more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If notice of the IRO decision is not provided to you in writing, the IRO must provide written confirmation of the decision to you and the Plan within forty-eight (48) hours after it is made.

What Happens After the IRO Decision is Made?

If the IRO's final external review decision reverses the Plan's internal adverse benefit determination,

upon the Plan's receipt of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

If the final external review upholds the Plan's internal adverse benefit determination, the Plan will continue not to provide coverage or payment for the reviewed claim.

If you are dissatisfied with the external review determination, you may seek judicial review to the extent permitted under ERISA section 502.

Subrogation/Right of Reimbursement

If you or your Dependent receives benefits from this Plan for bodily injuries or illnesses sustained from the acts or omissions of any third party, the Plan shall have the right to be reimbursed in the event you and/or your Dependent recovers all or any portion of the benefits paid by the Plan by legal action, settlement or otherwise, regardless of whether such benefits were paid by this Plan prior to or after the date of any such recovery. You and/or your Dependent will not be entitled to receive any benefits for such expenses under this Plan unless you and/or your Dependent agree in writing to all of the following conditions:

- To reimburse the Plan, to the extent of all benefits paid by this Plan as a result of such injuries, immediately upon obtaining any monetary recovery from any party or organization whether by action of law, settlement or otherwise by the execution of a Subrogation Agreement;
- To irrevocably assign to the Plan all rights to recover monetary compensation from the third party to the extent of all benefits paid by this Plan and to give notice of this assignment directly to such third parties, their agents or insurance carriers, or to any agent or attorney who may represent you or your Dependent. The assignment shall entitle the Plan to reimbursement from any sums held or received by the following third parties which are due to you and/or your Dependent prior to any distribution of funds to you and/or your Dependent, and shall provide that such parties shall hold such sums in trust as a fiduciary for the benefit of the Plan. The parties who shall be bound by such assignment are:
  - Any party or its insurance carriers making payments to or on behalf of the participant; or
  - Any agent or attorney receiving payments for or on behalf of you and/or your Dependent.
- To notify the Plan of any claim or legal action asserted against any third party or any insurance carrier(s) for such injuries as well as the name and address of such third parties, insurance carrier(s), any agent or attorney who is representing or acting on behalf of you and/or your Dependent or your estate, or any person claiming a right through you on a form to be supplied by the Plan;
- To cooperate fully with the Trustees in the exercise of any Assignment or Right of Subrogation, and not to take any action or refuse to take any action which would prejudice the rights of the Plan; and
- To acknowledge that this Plan shall have the Right of Recovery as provided under this Section should you and/or your Dependent fail to execute an Assignment, Subrogation Agreement or any other documents required herein, or breach any of the terms of this Section.

The order of proceeds from any settlement or judgment in any claim made against a third party will be allocated as follows:

- A sum sufficient to fully reimburse the Plan for all benefits advanced will be paid to the Plan;
- Any remainder, less reasonable attorney’s fee and a pro rata share of costs of prosecution, will be paid to you.

The order of proceeds will be made as outlined above, regardless of whether you or your Dependent has been fully compensated for the damages arising from injury, sickness or death.

In addition, the Trust shall have the independent right to bring suit in your and/or your Dependent’s name. The Trust shall also have the right to intervene in any action brought by you and/or your Dependent against any third party, to and including your insurance carrier under any uninsured or underinsured motorist provision or policy. You and/or your Dependent further must agree to take no action inconsistent with the requirements of this provision.

The Trustees expect full compliance with this Reimbursement Section. Therefore, the Trustees reserve the right to withhold future medical benefits from you and/or your Dependent if you and/or your Dependent have obtained a recovery from another source, as described above, and you and/or your Dependent has not reimbursed the Plan as required. Future benefits will be withheld in an amount equal to the amount previously owed to the Plan until such time as the Plan's claim for reimbursement has been completely satisfied. The Trustees also reserve the right to file suit against you and/or your Dependent if you fail to comply with the terms of the Plan or the Subrogation Agreement.

Privacy Policies

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully.

Background

The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), as amended by the Health Information Technology for Economic and Clinical Health Act (HITECH), requires health plans to notify plan participants and beneficiaries about its policies and practices to protect the confidentiality of their health information. This document is intended to satisfy HIPAA's notice requirement with respect to all health information created, received, or maintained by the California Ironworkers Field Welfare Plan for Active Employees and Their Eligible Dependents ("Health Plan" or "Plan").

The Health Plan needs to create, receive, and maintain records that contain health information about you to administer the Health Plan and provide you with health care benefits. This notice describes the Health Plan's health information privacy policy with respect to your medical, dental, vision, and prescription drug benefits that are not insured by a third party. The notice tells you the ways the Health Plan may use and disclose health information about you, describes your rights, and the obligations the Health Plan has regarding the use and disclosure of your health information. However, it does not address the health information policies or practices of your health care providers.

The following is a summary of the circumstances under which and purposes for which your health information may be used and disclosed. The privacy policies described in this section of the booklet do not apply to the life, dependent life, and AD&D benefits.

The privacy rules general allow the use and disclosure of your health information without your permission (known as authorization) for purposes of health care Payment activities, Health Care Operations and Treatment. Below are some examples of what that might entail:

Payment. Includes activities by this Health Plan, other plans, or providers to obtain premiums, make coverage determinations and provide reimbursement for health care. This can include eligibility determinations, reviewing services for medical necessity or appropriateness, utilization management activities, claims management, and billing; as well as "behind the scenes" plan functions such as risk adjustment, collection, or reinsurance. For example, the Health Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

To Conduct Health Care Operations. The Health Plan may use or disclose health information for its own operations to facilitate the administration of the Health Plan and as necessary to provide coverage and services to all of the Health Plan's participants and beneficiaries. Health care operations includes such activities as:

- Quality assessment, improvement activities, and patient safety activities.
- Activities designed to improve health or reduce health care costs.
- Clinical guideline and protocol development, case management and care coordination.
- Contacting health care providers and participants with information about treatment alternatives and other related functions. Health care professional competence or qualifications review and performance evaluation.

- Accreditation, certification, licensing or credentialing activities.
- Underwriting, premium rating or related functions to create, renew or replace health insurance or health benefits. The Health Plan does not use of disclose health information that is genetic information for underwriting purposes.
- Review and auditing, including compliance reviews, medical reviews, legal services and compliance programs.
- Business planning and development including cost management and planning related analyses and formulary development.
- Business management and general administrative activities of Health Plan, including customer service and resolution of internal grievances.

For example, the Health Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

Treatment. The Health Plan may use and disclose your health information to a health care provider who renders treatment on your behalf. For example, if you are unable to provide your medical history as a result of an accident, the Plan may advise an emergency room Physician about the types of prescription drugs you currently take. The Health Plan rarely, if ever, uses or discloses health information for treatment purposes.

Other allowable uses or disclosures of your health information.

The Plan is also allowed to use or disclose your health information without your written authorization for the following activities:

Business Associates. Certain services are provided to the Health Plan by third parties known as "business associates". For example, the Plan may input information about your health care treatment into an electronic claims processing system maintained by the Plan's business associate so your claim may be paid. In doing so, the Plan will disclose your health information to its business associate so it can perform its claims payment function. However, the Plan will require its business associates to appropriately safeguard your health information.

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

For Distribution of Health-Related Benefits and Services. The Health Plan may use or disclose your health information to provide your information on health-related benefits and services that may be of interest to you. However, the Health Plan will obtain your authorization if it uses your health information for marketing purposes (a communication that encourages you to use a product or service) if the Health Plan receives direct or indirect remuneration (payment) from the entity whose product or service is being marketed.

For Disclosure to the Plan Sponsor. The Health Plan may disclose your health information to the plan sponsor for plan administration functions performed by the plan sponsor on behalf of Health Plan. In addition, the Health Plan may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from health insurers or modify, amend or terminate the Plan. The Health Plan also may disclose to the plan sponsor information on whether you are participating in the Plan.

When Legally Required. The Health Plan will disclose your health information when it is required to do so by any federal, state or local law, including those that require the reporting of certain types of wounds or physical injuries.

To Conduct Health Oversight Activities. The Health Plan may disclose your health information to health oversight agencies authorized by law (audits, inspections, investigations, or licensing actions) for oversight of the health care system, government benefits programs for which health information is relevant to beneficiary eligibility, and compliance with regulatory programs and civil rights laws.

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

For Law Enforcement Purposes. As permitted or required by law, the Health Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, for example, to identify or locate a suspect, material witness, or missing person or to report a crime, the crime's location or victims, or the identity, description, or location of the person who committed the crime.

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

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

For Worker's Compensation. The Health Plan may release your health information to the extent necessary to comply with laws related to worker's compensation or similar programs.

For Victims of Abuse, Neglect, or Domestic Violence. The Health Plan may release your health information to government authorities, including social services or protected services agencies authorized by law to receive reports or abuse, neglect, or domestic violence, as required by law or if you agree or the Plan believes that disclosure is necessary to prevent serious harm to you or potential victims (you'll be notified of the Plan's disclosure if informing you won't put you at further risk).

For Public Health Activities. The Health Plan may release your health information as authorized by law for public health activities. These activities include preventing or controlling disease, injury or disability; reporting births and deaths; reporting child abuse or neglect; or reporting reactions to medication or problems with medical products or to notify people of recalls of products they have been using.

Coroners, Medical Examiners, and Funeral Directors. The Health Plan may release your health information to a coroner or medical examiner to identify a deceased person or to determine the cause of death. The Health Plan may also release your health information to a funeral director, as necessary to carry out his/her duty.

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

Research. Under certain circumstances, the Health Plan may disclose your health information for medical research purposes.

Individual Involved in Your Care or Payment of Your Care. The Health Plan may use or disclose your health information to a close friend or family member involved in or who helps pay for your health care. The Plan may advise a family member or close friend about your condition, your location (for example, that you are in the hospital), or death.

HHS Investigations. The Health Plan may release your health information to the Department of Health and Human Services ("HHS") to investigate or determine the Health Plan's compliance with the HIPAA privacy rule.

Authorization to Use or Disclose Health Information

Other than as stated above, the Health Plan will not disclose your health information other than with your written authorization. For example, the Health Plan will not use or disclose psychotherapy notes about you from your therapist without your authorization; however, the Health Plan is not likely to have access to or maintain these types of notes. If you authorize Health Plan to use or disclose your health information, you may revoke that authorization as allowed under the HIPAA rules. However, you can't revoke your authorization if the Plan has taken action relying on it. In other words, you can't revoke your authorization with respect to disclosures the Plan has already made.

Your Rights With Respect to Your Health Information

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

Right to Request Restrictions. You have the right to ask the Plan to restrict the use and disclosure of your health information for Treatment, Payment or Health Care Operations, except for uses or disclosures required by law. You have the right to request a limit on Health Plan's disclosure of your health information to family members, close friends, or other persons you identify as being involved in your care or payment for your care. However, the Health Plan is not required to agree to your request. And if the Plan does agree, a restriction may later be terminated by your written request, by agreement between you and the Plan, or unilaterally by the Plan for health information created or received after you're notified that the Plan has removed the restrictions. If you wish to make a request for restrictions your request must be in writing. For further information, please contact the Privacy Official or its designee.

Right to Receive Confidential Communications. You have the right to request that the Health Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. For example, you may ask that the Health Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to Privacy Official or its designee. The Health Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You (or your personal representative) have the right to inspect and obtain a copy of your health information (in hardcopy or electronic form) contained in a "designated record set," for as long as the Health Plan maintains the health information. You may request your hardcopy or electronic information in a format that is convenient for you, and the Health Plan will honor that request to the extent possible. You also may request a summary of your health information.

The Health Plan must provide the requested information within 30 days. A single 30-day extension is allowed if the Health Plan is unable to comply with the deadline and if the Health Plan provides you with a notice of the reason for the delay and the expected date by which the requested information will be provided.

A request to inspect and copy records containing your health information must be made in writing to the Privacy Official or its designee. If you (or your personal representative) request a copy of your health information, the Health Plan may charge a reasonable, cost-based fee for copying, creating, or preparing the requested information.

If access is denied, you or your personal representative will be provided with a written denial setting forth the basis for the denial, a description of how you may exercise your review rights, and a description of yow you may complain to the Secretary of the U.S. Department of Health and Human Services (HHS).

Right to Amend Your Health Information. You have the right to request that the Health Plan amend your health information or record about you in a designated record set for as long as the health information is maintained in the designated record set.

The Health Plan has 60 days after receiving your request to act on it. The Health Plan is allowed a single 30-day extension if the Health Plan is unable to comply with the 60-day deadline.

A request for an amendment of records must be made in writing to the Privacy Official or its designee.

The Health Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Health Plan, if the health information you are requesting to amend is not part of the Health Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if Health Plan determines the records containing your health information are accurate and complete.

If the Health Plan denied your request in whole or in part, the Health Plan must provide you with a written denial that explains the basis for the decision. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your health information.

Right to an Accounting. You have the right to request a list of certain disclosures the Plan has made of your health information. This is often referred to as an "accounting of disclosures." You may receive information on disclosures of your health information going back for six (6) year from the date of your request. You do not have a right to receive an accounting of any disclosures made:

- For Treatment, Payment, or Health Care Operations;
- To you about your own health information;
- Incidental to other permitted or required disclosures;
- Where authorization was provided;
- To family members or friends involved in your care (where disclosure is permitted without authorization);
- For national security or intelligence purposes or to correctional institutions or law enforcement officials in certain circumstances; or
- As part of a "limited data set" (health information that excludes certain identifying information.

In addition, your right to an accounting of disclosures to a health oversight agency or law enforcement official may be suspended at the request of the agency or official.

If you want to exercise this right, your request must be made in writing to the Privacy Official or its designee. The request should specify the time period for which you are requesting the information. You may make one (1) request in any 12-month period at no cost to you, but the Plan may charge a reasonable, cost-based fee for each subsequent request. You'll be notified of the fee in advance and have the opportunity to change or revoke your request.

The Health Plan has 60 days to provide the accounting. The Health Plan is allowed an additional 30 days if the Health Plan gives you a written statement of the reasons for the delay and the date by which the accounting will be provided.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Notice at any time, even if you have received this Notice previously or agreed to receive the Notice electronically. To obtain a paper copy, please contact the Privacy Official or its designee.

Duties of the Health Plan. The Health Plan is required by law to maintain the privacy of your health information and to provide you with this Notice of the Plan's legal duties and privacy practices with respect to your health information. If you participate in an insured plan option, you will receive a notice directly from the Insurer. In addition, if a breach of your unsecured health information occurs, the Health Plan will notify you.

Changes to the Information in this Notice

The Plan must abide by the terms of this Notice. However, the Plan reserves the right to change the terms of its privacy policies as described in this Notice at any time, and to make new provisions effective for all health information that the Plan maintains. This includes health information that was previously created or received, not just health information created or received after the policy is changed. If a material change is made to the Plan's privacy policies described in this Notice, you will be provided with a revised Privacy Notice, which will be sent to you in the same manner as this Notice was provided.

Complaints

If you believe your privacy rights have been violated, you may complain to the Plan and to the Secretary of Health and Human Services. You won't be retaliated against for filing a complaint. To file a complaint, contact the Privacy Official or its designee.

Breach of Health Information

The Plan will inform you if a breach of your unsecured health information occurs.

Security of Health Information

The Plan Sponsor will:

Implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of electronic PHI that it creates, receives, maintains, or transmits on behalf of the group health plan;

Ensure that the adequate separation discussed in Item (4) above, specific to electronic PHI, is supported by reasonable and appropriate security measures;

- Ensure that any agent, including a subcontractor, to whom it provides electronic PHI agrees to implement reasonable and appropriate security measures to protect the electronic PHI; and
- Report to the Plan any security incident of which it becomes aware concerning electronic PHI.

Contact Person

For more information on the Plan's privacy policies or your rights under HIPPA, contact the Privacy Official or its designee at 131 N. El Molino Ave., Suite 330, Pasadena, Ca 91101/626-792-7337.

Administrative Information About The Plan

Plan Sponsor and Administrator

The Plan is sponsored and administered by the Board of Trustees. The Board of Trustees consists of employer and union representatives selected by the employers and unions who have entered into collective bargaining agreements, which relate to this Plan. If you wish to contact the members of the Board of Trustees you may use the address below:

Union	Management
Mr. Johnny Galvan Ironworkers Local 229 5155 Mercury Point San Diego, CA 92111	**Mr. Dennis Andersen** Pacific Erectors, Inc. 4460 Yankee Hill Road Rocklin, CA 95677
Mr. Charles Hernandez Ironworkers Local 377 570 Barneveld Avenue San Francisco, CA 94124	**Mr. Richard Barbour** The Herrick Corporation 2000 Crow Canyon Place, Suite 360 San Ramon, CA 94583
Mr. Hart Keeble Ironworkers Local 416 13830 San Antonio Drive Norwalk, CA 90650	**Mr. Steve Davis** CMC Rebar 12451 Arrow Route Etiwanda, CA 91739
Mr. Jeff McEuen Ironworkers Local 378 3120 Bayshore Road Benicia, CA 94510	**Mr. Charles L. Krebs** Rebar Engineering, Inc. 10706 Painter Avenue Santa Fe Springs, CA 90670
Mr. Karl Pineo Ironworkers Local 118 2840 El Centro Road, St. 118 Sacramento, CA 95833	**Mr. Greg McClelland** Western Steel Council 990 Reserve Drive #104 Roseville, CA 95678
Mr. Don Savory 5407 E. Olive, Suite 16 Fresno, CA 93727	**Mr. Dave McEuen** California Erectors Bay Area 4500 California Court Benicia, CA 94510
Mr. Don Silvery Ironworkers Local 433 17495 Hurley Street East City of Industry, CA 91744	**Mr. Michael Vlaming** Industrial Contractors UMIC, Inc. 447 Georgia Street Vallejo CA 94590
Terry Wright Ironworkers Local 75 950 E. Elwood Street Phoenix, AZ 85040	**Mr. Daniel Welsh** Washington Iron Works 17926 S. Broadway Gardena, CA 90248
Donald Zampa District Council of Ironworkers 1660 San Pablo Avenue, St. C Pinole, CA 94564	

Contract Administrator

The Board of Trustees has delegated administrative responsibilities to following organization:

Administrator

Ironworker Employees' Benefit Corporation
131 N. El Molino Avenue, Suite 330
Pasadena, CA 91101-1878
800-527-4613

Parties to the Collective Bargaining Agreement

Contributions to this Plan are made on behalf of each employee in accordance with collective bargaining agreements between Local Unions 75, 118, 155, 229, 377, 378, 416, 433, and 844 of the International Association of Bridge, Structural and Ornamental Ironworkers and employers in the industry. A copy of any such collective bargaining agreement may be obtained upon written request to the Trust Fund Office and is available for examination by Employees and Dependents.

Participants and Dependents may obtain, upon written request to the Trust Fund Office, information as to whether a particular employer or employee organization is a sponsor of the Plan and the address of a particular employer and whether an employer is required to pay contributions to the Plan. A copy of any such agreement may be obtained by Plan participants upon written request to the Plan Administrator, and is available for examination by Plan participants.

Plan Name and Numbers

The name of the Plan is the California Ironworkers Field Welfare Plan for Active Employees and Their Eligible Dependents. The Plan number is 501.

The employer identification number (EIN), assigned to the Board of Trustees by the Internal Revenue Service, is 95-6042868. Taken together, the Plan's name, number, and the Trustees' EIN identify our Plan with government agencies.

Agent for Service of Legal Process

The Board of Trustees is the Plan's agent for service of legal process. Accordingly, if legal disputes involving the Plan arise, any legal documents should be served upon the Board of Trustees at the address of the California Ironworkers Field Welfare Plan Trust Fund Office. However, such documents may also be served upon any individual Trustee or to the following organization:

Plan Funding

Employer contributions and self-contributions finance the benefits described in this booklet. All employer contributions are paid to the Trust Fund subject to provisions in the collective bargaining agreements between the unions and employers. The Board of Trustees holds all assets in trust. Benefits and administrative expenses are paid from the Plan.

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

Fiscal Year

The accounting records of the Plan are kept beginning on each June 1st and ending the following May 31st.

Type of Plan

This Plan is considered a welfare plan, providing the following benefits: a choice between a self-funded medical/prescription plan or one of the medical health maintenance organizations contracted with the Plan; a choice between a self-funded dental/orthodontic plan and one of the prepaid dental plans; an insured EAP/mental health and substance abuse treatment plan administered through MHN; a self-funded vision plan administered through VSP and Spectera; and self-funded Life/AD&D benefit.

Rights of the Board of Trustees

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

The Board of Trustees intends to continue these benefits as long as sufficient Trust Fund assets are available. However, the Trustees reserve the right to amend or modify any Plan benefits or to terminate the Plan. In the event of termination of the Plan, any and all assets remaining after payment of all obligations and expenses will be used in accordance with a dissolution plan adopted by the Trustees to continue the benefits provided by the existing Plan until such assets have been exhausted or in such manner as will best serve the purposes of the Fund. In no event will assets be paid to or be recoverable by any contributing employer, association or labor organization. The Trust Fund recognizes that new technologies may develop which are not specifically addressed. The Trust Fund reserves the right to determine whether or not a service or supply is covered, and if covered, to determine Allowed Charges. If a Participant selects a more expensive service or supply than is customarily provided, or specialized techniques rather than standard procedures, the Trust Fund reserves the right to consider alternate professionally acceptable services and supplies as the basis for benefit consideration.

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

Authority to Change Plan

The Board of Trustees of the California Field Ironworkers Welfare Plan expressly reserves the right to amend, modify, revoke or terminate the Plan in whole or in part, at any time. Benefits provided under this Plan are not vested. The Board of Trustees expressly reserves the right, in its sole discretion to?

- Terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already accrued; and
- Alter or postpone the method of payment of any benefit; and

- Amend, terminate or rescind any provision of the Plan, and
- Merge the Plan with other plans, including the transfer of assets.

The authority to make any such changes to the Plan rests solely with the Board of Trustees. Any such amendment, modification, revocation, or termination of the Plan shall be made by a resolution adopted by the Board of Trustees. 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 of Trustees.

Availability of Plan Resources

It is recognized that benefits provided by the Plan can be paid only to the extent that the Plan has available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide benefits established hereunder, beyond the obligation of the Contributing Employer to make contributions as stipulated in its Collective Bargaining Agreement. In the event that at any time the Plan does not have sufficient assets to permit continued payments, nothing contained in the Plan document shall be construed as obligating any Contributing Employer to make benefit payments or contributions (other than contributions for which the Contributing Employer may be obligated under its Collective Bargaining Agreement) in order to provide benefits.

There shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, signatory association or other person or entity of any kind to provide benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments. Benefits provided under this Plan are paid directly from Plan assets, and there is not liability on the Board of Trustees or any other entity to provide payment over and beyond the amount in the Plan collected and available for such purpose.

In the event of termination of the Plan, any and all monies and assets remaining in the Plan, after payment of expenses, shall be used for the continuance of benefits, provided by the then existing benefits, until such monies and assets have been exhausted.

Primacy of Workers' Compensation Laws

The benefits provided by this Plan are not in lieu of and do not affect any requirement for coverage by workers' compensation insurance laws, employer's liability laws, occupational disease laws, or similar legislation.

Right to Recover Excess Payments

Whenever a benefit payment has been made by this Plan that exceeds the amount that should have been paid under the provisions of the Plan, the Plan shall have the right to recover, including the right to offset against future benefit payments, such excess amounts from any person or organization to, or for whom, said payments were made or from any person whose intentional or negligent acts, omissions, or representations caused such excess amounts to be paid, provided that no claimant shall be required to pay more than the amount actually received in error or more than the amount paid by the Plan to a provider for which the claimant was actually liable to such provider. In the event the Plan brings legal action to recover any such excess amount, the Plan shall be entitled to recover its costs and attorney's fees incurred in such action.

Notice and Payment of Claims

Benefits will be paid by the Plan to the claimant unless payment has been assigned to the provider, as they

accrue upon receipt of written proof, satisfactory to the Plan, covering the occurrence, character and extent of the event for which the claim is paid. Benefits will be paid by the Plan only if notice of claim is made within one year from the date on which Allowable Charges were first incurred unless it shall be shown that it was not reasonably possible to give notice within such time limit. Proof of claim forms, as well as other forms, and method of administration and procedure will be solely determined by the Board of Trustees.

Your ERISA Rights

As a participant in the California Ironworkers Field Welfare Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the Plan Administrator's office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the Employee Benefits Security Administration of the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration of the U.S. Department of Labor.

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 ***SPD***. The Administrator may make a reasonable charge for the copies.

Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each participant with a copy of this Summary Annual Report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, spouse or Dependents if there is a loss of coverage under the plan as a result of a qualifying event. You or your Dependents must pay for such coverage.

Review this ***SPD*** and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

There is a reduction or elimination of exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan participants ERISA imposes duties upon the people who are responsible for the operation of the Employee Benefit Plan. 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. 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

If your claim for a health 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.

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

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 of the U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration of the U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration. For single copies of publications, contact the Employee Benefits Security Administration Brochure Request Line at 1-800-998-7542 or contact the EBSA field office nearest you.

You may also find answers to your plan questions at the EBSA's website at http://www.dol.gov/dol/ebsa/. A list of EBSA Field Offices is located at http://www.dol.gov/dol/ebsa/.

Glossary of Terms

Active Employee or Employee

The term "Active Employee" shall mean any person who, by reason of their active employment, meets the eligibility requirements hereunder as established by the Plan and as amended from time to time. Refer to the section of this SPD entitled "Becoming a Plan Participant."

Allowable Charges

The "Allowable Charge" for Non-Contract Providers is the lesser of:

- The charge billed by the Physician or other provider, or
- The maximum benefit allowable as determined at the sole discretion of the Board of Trustees as the appropriate payment for the service(s) rendered.

Alternate Recipient

The term "Alternate Recipient" shall mean a child of an Active Employee who is eligible for benefits from the Plan as a Dependent pursuant to the provisions of a Qualified Medical Child Support Order.

Approved Clinical Trial

The term "Approved Clinical Trial" shall mean a Phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The Approved Clinical Trial's study or investigation must be (1) approved or funded by one or more of: (a) the National Institutes of Health (NIH), (b) the Centers for Disease Control and Prevention (CDC), (c) the Agency for Health Care Research and Quality (AHCRO), (d) the Centers for Medicare and Medicaid (CMS), (e) a cooperative group or center of the NIH, CDC, AHCRO, CMS, the Department of Defense (DOD), or the Department of Veterans Affairs (VA), (f) a qualified non-governmental research entity identified by HIH guidelines for grans, or (g) the VA, DOD, or Department of Energy (DOE) if the study has been reviewed and approved through a system of peer review that the Secretary of HHS determines is comparable to the system used by NIH and assures unbiased review of the highest scientific standards by qualified individuals who have no interest in the outcome of the review; (2) a study or trial conducted under an investigational new drug application reviewed by the Food and Drug Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

Contract Provider

The term "Contract Provider" shall mean a Hospital, Physician, or other Health Care Provider under contract with the Plan's contracting organization to provide health care services and supplies at negotiated rates as payment in full, except with respect to the Copay or coinsurance percentage for which the Eligible Individual is responsible.

Contract Rate

The amount that a Contract Provider has agreed by contract with the preferred provider organization or other network service organization to accept for the services rendered.

Contributions

The term "Contributions" shall mean the contributions specified by the Collective Bargaining Agreements to be made by the Employers to the California Ironworkers Field Welfare Plan.

Cosmetic Surgery

The term "Cosmetic Surgery" means surgery or treatment to change the shape or structure of, or otherwise alter a portion of the body, performed solely or primarily for the purpose of improving appearance and not as a result of a disease or condition which, in accordance with accepted medical practice, requires surgical intervention to cure, alleviate pain, or restore function. Restorative surgery performed during or following mutilative surgery required as a result of Illness or Injury shall not be considered cosmetic. The Board of Trustees or its designee has the sole discretionary authority to determine if a surgery or treatment is "cosmetic."

Covered (or Allowable) Charges

The term "Covered Charges" means the expenses incurred by an individual while eligible under the Plan, which are not excluded and which are payable in whole or in part under the terms of the Plan.

Custodial Care

The term "Custodial Care" shall mean care and services (including room and board needed to provide that care or services) given mainly for personal hygiene or to perform the activities of daily living. Some examples of Custodial Care are training or helping patients to get in and out of bed, as well as help with bathing, dressing, feeding or eating, use of the toilet, ambulating, or taking 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.

Dependent

The term "Dependent" means:

- Your spouse. "Spouse" means the person to whom an Employee is legally married, as determined by applicable state law, until the marriage is ended by divorce or legal separation. A spouse who is also eligible as an Employee or Retiree will also be covered as your Dependent.
- Your same-sex Domestic Partner **(only in California and only to participants enrolled in an HMO plan)** who: (1) lives with you, the Employee; (2) is at least age 18; and (3) is your sole Domestic Partner. The Plan will require that you provide evidence of your domestic partnership by providing either: (1) a certificate of domestic partnership from any city, county, or state offering the ability to register a domestic partnership and such partnership has not been dissolved; or (2) at least three of the following documents: (a) a joint lease, mortgage, or deed; (b) joint ownership of a vehicle; (c) joint ownership of a checking account or credit account; (d) designation of the Domestic Partner as a beneficiary for your life insurance or retirement benefits; (e) designation of the Domestic Partner as a beneficiary of your will; (f) designation of your Domestic Partner as holding a power of attorney for your health care; or (g) shared household expenses. The children of your Domestic Partner will be covered by the Plan and treated as your stepchild(ren). You will need to report, as taxable income, the fair market value of the portion of Plan coverage for your Domestic Partner and any of his or her children that is employer paid.
- Your Dependent child up to the end of the calendar month in which the child attains age 26. Dependent children who can be covered up to age 26 include:
  - Your natural children (including children born out of wedlock if you, the Active Employee, are identified as the parent by birth certificate or appropriate judicial decree);
  - Legally adopted children and children placed with you for adoption; and
  - Stepchildren of the Active Employee.

- A Dependent child can include an unmarried child up to age 21for whom you, the Active Employee, have been named the legal guardian by a court, provided the child is someone:
    - Who maintains a principal place of residence in your home and is a member of your household for the entire calendar year;
    - Who is dependent on you for more than one-half of his or her support;
    - For whom you have received a court decree or order of legal guardianship; and
    - Who is not claimed as any other person's dependent child during the calendar year.
- A child that the Plan is required to cover for benefits under a Qualified Medical Child Support Order (QMCSO). Notify the Trust Fund Office if you become aware of an order like this. Such an order could have an effect on your benefit coverage or elections. Refer to the Glossary of Defined Terms for the definition of a QMCSO. A free copy of the Fund's QMCSO procedures is available from the Trust Fund Office.

Eligibility may be continued past age 26 for an unmarried Dependent child who is physically or mentally disabled and who chiefly depends on the Employee for support and maintenance. Proof of incapacity must be provided. The disabling condition must have been present before the child reaches the age of 21.

When both parents are Active Employees eligible under this Plan, eligible children will be covered as Dependents of both parents.

Drugs

The term "Drugs" shall mean any article which may be lawfully dispensed, as provided under the federal Food and Drug Administration, only upon a written or oral prescription of a Physician or Dentist licensed by law to administer it.

Durable Medical Equipment

The term "Durable Medical Equipment" means equipment that can withstand repeated use, is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness, is not disposable or non-durable and is appropriate for use in the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, commodes, electric hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Eligible Individual

The term "Eligible Individual" shall mean any person eligible for benefits under the Plan, whether as an eligible Active Employee or eligible Dependent.

Emergency Medical Condition

The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson, who possesses average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in the following: placing the health of the person (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; serious impairment to bodily functions; or serious dysfunction of any bodily organ or part.

Final determination as to whether services were rendered in connection with an Emergency will be made by the Plan.

Employer or Contributing Employer

The term "Employer" or "Contributing Employer" means an Employer who is required to make a contribution on the eligible Active Employee's behalf to the Plan under the terms of a Collective Bargaining Agreement. This term also includes eligible employees of I.E.B.C. and the Apprenticeship union locals.

Experimental

The term "Experimental" shall mean any medical procedure, equipment, treatment or course of treatment, drug or medicine which is not normally and regularly used or prescribed by the medical community, for the reason that it remains under clinical or laboratory investigation, or has not been exposed to clinical or laboratory investigation.

The Fee-For-Service Plan will cover routine costs associated with certain approved clinical trials related to cancer or other life-threatening illnesses. This means that routine costs, services and supplies will be payable during the time the eligible individual is participating in the clinical trial. The Plan's standard benefits will apply.

In order to qualify for this coverage, a participant must be in an approved clinical trial according to the trial protocol with respect to the treatment of cancer or another life-threatening disease or condition, and either:

(1) the referring health care professional is a participating provider and has concluded that the participant's participation in such trial would be appropriate; or

(2) the participant provides medical and scientific information establishing that his or her participation in such trial would be appropriate.

Participants are generally required to participate in clinical trials through a Contract Provider. The Welfare Plan will not provide coverage for Non-Contract Provider costs associated with clinical trials, unless the clinical trial is only offered outside the Participant's state of residence or if no Contract Provider will accept the Participant for participation in the trial.

If you wish to participate in a clinical trial, you should contact the Fund Office for more information and to make sure you meet the requirements for coverage. In addition, pre-certification by Anthem for inpatient services and preauthorization by PHA for outpatient services is required. If you fail to obtain pre-authorization or pre-certification when it is required, the Plan's payment percentage will be reduced by 10%, and you will be responsible for an additional 10% coinsurance.

For purposes of coverage of routine costs associated with approved clinical trials:

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

Administration (FDA); or (3) a drug trial that is exempt from investigational new drug application requirements.

He, Him, His, and Himself

The terms "He", "Him", "His", and "Himself" shall apply to both genders wherever used.

Health Maintenance Organization or HMO

The term "Health Maintenance Organization" or "HMO" shall mean Hospital-Medical-Surgical benefits provided by an organization licensed under the federal HMO Act or the California Knox-Keene Act.

Hospice Care Program

The term "Hospice Care Program" shall mean a coordinated, interdisciplinary program approved by a Terminally Ill Individual's attending Physician and the medical director of the hospice, for the meeting of special physical, psychological, spiritual and social needs of the terminally ill individual and his parents, spouse, and/or children.

If approved by the attending Physician and hospice director, the Hospice Care Program may be extended for a period up to six months.

Hospital

The term "Hospital" means a state or federally licensed institution that meets all of the following requirements:

- It is primarily engaged in providing diagnostic, surgical and therapeutic facilities for medical and surgical care of sick and injured persons on an inpatient basis at the patient's expense.
- It continuously provides 24-hour-a-day supervision by a staff of Physicians licensed to practice medicine (other than Physicians whose license limits their practice to one or more specified fields) and 24-hour-a-day nursing care by or under the supervision of registered nurses (R.N.'s).
- It is not, other than incidentally, a place of rest, a nursing home, a convalescent home, a place for the aged, a pain clinic or a place for recovery from drug or alcohol addictions.

Hour Bank

The term "Hour Bank" means the account established for an Active Eligible Employee to which all hours are credited from contributing Employers for which contributions are made or are required to be made to the Plan on his behalf. One hundred hours are deducted from the Eligible Active Employee's Hour Bank for each month of eligibility. The maximum hours in an Eligible Active Employee's Hour Bank cannot exceed 600 after the deduction of 100 hours for the current month's eligibility.

Licensed Pharmacist

The term "Licensed Pharmacist" means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Medically Necessary

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

- Appropriate and necessary for the symptoms, diagnosis or treatment of the Injury or Illness;

- Not Experimental, as defined above, or primarily to enhance educational achievement or social functioning;
- Within the standards of good medical practice accepted and followed by the medical community;
- Not primarily for the convenience of the Eligible Individual, the Eligible Individual's Physician or another provider;
- The most appropriate supply or level of service that can be safely provided. For Hospital stays, this means that acute care as an inpatient is necessary due to the kind of services the Eligible Individual is receiving or the severity of the Eligible Individual's condition, and that safe and adequate care cannot be received as an outpatient or in a less intensified medical setting; and
- Not primarily for Custodial Care.

Medicare

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

Morbid Obesity

The term "Morbid Obesity" means the presence of morbid obesity that has persisted for at least 5 years, defined as either:

- Body mass index exceeding 40; or
- BMI greater than 35 in conjunction with ANY of the following severe co-morbidities:
    - Coronary heart disease; or
    - Type 2 diabetes mellitus; or
    - High blood pressure/hypertension (blood pressure greater than 140 mmHg systolic and/or 90 mmHg diastolic despite optimal medical management);

AND

- Individual has completed growth (18 years of age or documentation of completion of bone growth);

AND

- Individual has participated in a Physician-supervised nutrition and exercise program (including dietician consultation, low calorie diet, increased physical activity, and behavioral modification), documented in the medical record. This Physician-supervised nutrition and exercise program must meet ALL of the following criteria:
    - Participation in nutrition and exercise program must be supervised and monitored by a Physician working in cooperation with dieticians and/or nutritionists; AND
    - Nutrition and exercise program must be 6 months or longer in duration; AND
    - Nutrition and exercise program must occur within the two years prior to surgery; AND
    - Participation in Physician-supervised nutrition and exercise program must be documented in the medical record by an attending Physician who does not perform bariatric surgery. Note: A Physician's summary letter is not sufficient documentation.

Non-Contract Provider

The term "Non-Contract Provider" shall mean a Hospital, Physician, or other Health Care Provider that

does not contract with the Plan's contracting organizations to provide health care services and supplies at negotiated rates.

Open Enrollment Period

The period during which an employee may add dependents, change and/or elect different coverage or select among the alternate health benefit programs that are offered by the Fund. The annual Open Enrollment Period will be announced each fall with eligibility for your choices beginning January 1st of the next calendar year.

Outpatient Surgical Center

The term "Outpatient Surgical Center" or "Surgi-Center" shall mean a state licensed or Medicare approved facility, which is not a Hospital, but meets all of the following requirements:

- It is primarily engaged in providing diagnostic and surgical facilities for ambulatory, outpatient surgical care;
- It is equipped with permanent facilities for diagnosis and surgery and is staffed by Registered Nurses, Physicians and Anesthetists licensed to practice medicine; and
- It is a place other than the Physician's office or surgical suite.

Physician, Surgeon or Doctor

The terms "Physician" or "Surgeon" or "Doctor" shall mean a licensed Doctor of Medicine (M.D.), or Doctor of Osteopathy (D.O.) a Dentist (D.D.S.), licensed Podiatrist (D.P.M.), Chiropodist or Chiropractor (D.C.), Psychologist, Physician Assistant, or Certified Acupuncturist who are all practicing within the scope of their licenses. A Certified Optometrist shall be considered a Physician, for diagnosis and treatment of eye conditions within the scope of his license. Where a Physician is specifically defined in a benefit provision that definition shall prevail over this general definition. The term Physician shall not include any person who is the spouse, child, brother, sister, or parent of the Active Employee or his spouse. Notwithstanding the foregoing, a Physician will include any type of health care provider, as long as that individual is licensed to perform the covered services, and is performing services within the scope of that license, as defined and regulated under the laws of the State in which the provider is practicing.

Plan

The term "Plan" shall mean the California Ironworkers Field Welfare Plan adopted and thereafter amended by the Board of Trustees as described in this SPD and includes insurance policies, HMO policies, Evidence of Coverage documents, written policy and procedure documents that have been formally adopted by the Board of Trustees and all other legal documents governing the Plan, including the Trust Agreement establishing the California Ironworkers Field Welfare Plan.

Qualified Medical Child Support Order

The term Qualified Medical Child Support Order, including a National Medical Support Order, means an order providing benefit payments to an Alternate Recipient, which meets all of the requirements of the Employee Retirement Income Security Act of 1974 (ERISA), as amended by the Omnibus Budget Reconciliation Act of 1993 (OBRA '93) or thereafter, including approval as a qualified order by the Plan.

A qualified medical child support order (QMCSO) could have an effect on your benefit coverage or elections. A "Medical Child Support Order is a Court Order which:

- Provides for child support or health benefit coverage with respect to a child of a participant under the Plan; and

- Is made pursuant to a state domestic relations law or National Medical Support Order; and
  - Either relates to benefits under the Plan, or
  - Enforces a law relating to medical child support under section 1908 of the Social Security Act.

A "Qualified" Medical Child Support Order is a Medical Support Order which:

- Creates, assigns, or recognizes a child's right to receive benefits for which a participant is eligible under the Plan;
- Clearly specifies the name and last known mailing address of the participant and child; however, the name and mailing address of a state or local government official may be substituted for the mailing address of the child if the order so provides;
- Clearly specifies the type of coverage to be provided by the Plan to the child;
- Clearly specifies the period of time for which the order applies;
- Clearly specifies the plans to which the order applies; and
- Does not require the plan to provide any benefits not already provided, except as specified in Section 1908 of the Social Security Act.

Notify the Trust Fund Office if you become aware of an order like this. A copy of the Fund's QMCSO procedures is available free-of-charge from the Trust Fund Office.

Registered Nurse

The term "Registered Nurse" (R.N.) means an individual licensed by the Board of Registered Nursing of the state of California or comparable authority to operate within the scope of his or her license; and who does not ordinarily reside in the home of the Active Employee and who is not the spouse, child, brother, sister, or parent of the Active Employee or his spouse.

Skilled Nursing Facility

The term "Skilled Nursing Facility" means a public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets all of the following requirements:

- It is accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
- It is regularly engaged in providing room and board and continuously provides 24 hour-a-day Skilled Nursing Care of sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
- It provides services under the supervision of Physicians; and
- It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with one licensed Registered Nurse on duty at all times; and
- It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
- It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill, or suffering from tuberculosis; and

- It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital will be considered a Skilled Nursing Facility for the purposes of the Indemnity Medical Plan.

Terminally Ill Individual

The term "Terminally Ill Individual" means a person whose life expectancy is six months or less.

Total Disability or Totally Disabled

The term "Total Disability" or "Totally Disabled" shall mean, because of bodily injury or illness, an Eligible Active Employee is unable to engage in any occupation for wages or profit.

Trust Agreement

The term "Trust Agreement" means the Agreement and Declaration of Trust establishing the California Ironworkers Field Welfare Plan dated March 1, 1953 and any modification, amendment, extension or renewal thereof.

Trust Fund Office

The term "Trust Fund Office" shall mean the Ironworker Employees' Benefit Corporation.

Trustees

The term "Trustees" shall mean persons designated as Trustees pursuant to the terms of the Trust Agreement, and the successors of such persons, from time to time, in office. The term "Board of Trustees" and "Board" means the Board of Trustees established by the Trust Agreement.

Union

The term "Union" means any of the local unions and district council affiliated with the International Association of Bridge, Structural, and Ornamental Ironworkers signatory hereto.

Urgent Care Center

The term "Urgent Care Center" shall mean a facility that meets all of the tests that follow:

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

Utilization Management

The term "Utilization Management" means, with regard to the Fee-For-Service Medical Benefits, 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;
- 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 are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan.

Utilization Management Company

The term "Utilization Management Company" means the independent utilization management organization, staffed with licensed health care professionals, operating under a contract with the Plan to administer the Plan's Utilization Management services.

Value Based Site

The term "Value Based Site" means a Contracted Hospital in California that will hold costs under the Maximum Allowable Charge for a total hip replacement and total knee replacement.