CALIFORNIA SERVICE EMPLOYEES HEALTH AND WELFARE TRUST FUND

SUMMARY PLAN DESCRIPTION (SPD)
&
PLAN DOCUMENT

Effective June 1, 2023

FUND OFFICE

California Service Employees Health & Welfare Trust Fund

2323 Eastlake Ave East
Seattle, WA 98102

CLAIMS PAYING OFFICE

(Indemnity Medical and Indemnity Dental Plans)

Northwest Administrators

2323 Eastlake Ave East
Seattle, WA 98102
(844) 492-9158

LOS ANGELES FRINGE BENEFIT OFFICE

Membership Services

828 W. Washington Blvd.
Los Angeles, CA 90015
(877) HWC-ASRV (492-2778)
(213) 747-7551

EMPLOYER TRUSTEES

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LEGAL COUNSEL

Saltzman & Johnson Law Corporation
Weinberg, Roger & Rosenfeld

CONSULTANT

The Segal Company

IMPORTANT NOTICES

PRIVACY OF YOUR HEALTH INFORMATION

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

The Plan's Notice of Privacy Practices, distributed to all Plan participants when they first become eligible, explains what information is considered "Protected Health Information." It also tells you when the Plan may use or disclose this information, when your permission or written authorization is required, how you can get access to your information, and what actions you can take regarding your information.

If you have misplaced your copy of the Plan's privacy notice, please contact the Fund Office to request a replacement.

AVAILABILITY OF PLAN RESOURCES

Benefits provided by the Plan can be paid only to the extent that there are available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide benefits beyond the obligation to make contributions as stipulated in the Collective Bargaining Agreements or Trust Agreements of the Fund. In the event that at any time the Plan does not have sufficient assets to permit continued payments, nothing in the Plan shall be construed as obligating any Contributing Employer to make payments in order to provide Plan benefits.

There is no liability on the Trustees, individually or collectively, or upon any Employer, the Union, signatory association or other person or entity to provide benefits if the Plan does not have sufficient assets to make benefit payments.

DEPENDENT SOCIAL SECURITY NUMBERS NEEDED

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Plan Administrator, or its designee, the Social Security Number (SSN) of your Eligible Dependents for whom you have elected, or are electing, Plan coverage, and information on whether you or any of such dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Plan coverage but may also be requested at a later date.

If a dependent does not yet have a social security number, you can go to this website to complete a form to request a SSN: http://www.socialsecurity.gov/online/ss-5.pdf. Applying for a social security number is FREE. If you do not have a social security number, call the Fund Office for a copy of the Safe Harbor Form.

Failure to provide the SSN or failure to complete the CMS model form (form is available from the Claims Administrator or at www.cms.gov) means that claims for eligible individuals may not be considered a payable claim for the affected individuals.

Lastly, please let the Fund know if you or any covered dependents are on dialysis at this time or start dialysis in the future.

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MESSAGE FROM THE TRUSTEES ABOUT YOUR BENEFITS

The California Service Employees Health and Welfare Trust Fund directly self-funds the indemnity medical and prescription drug plans, the indemnity dental plan, and vision benefits. Depending on the Collective Bargaining Agreement between your Signatory Employer and your Service Employees International Union – CTW, you may also be eligible to enroll in a Kaiser HMO Plan. Likewise, the Collective Bargaining Agreement determines if you are eligible for prescription drug, dental, vision and life insurance benefits.

This Plan Document/Summary Plan Description (SPD) has been prepared to provide you with the following information:

- A brief overview of how you become eligible for benefits and when your benefits terminate. However, the ***Collective Bargaining Agreement*** between your Signatory Employer and your Service Employees International Union – CTW, provides the definitive rules, which determine your eligibility for benefits.
- The rules under the federal law known as **COBRA** that allows you to temporarily extend your coverage when it would otherwise terminate.
- A description of other circumstances under which you may be eligible to extend your coverage when it might otherwise terminate, such as when you become disabled, are granted a family medical leave by your Employer, or when you enlist in or are called up to military service.
- A description of how the indemnity medical and prescription drug plans work, including definitions of important terms, other benefits that are provided, your rights and responsibilities, and plan limitations and exclusions. However, the specific medical and prescription benefits provided to you are determined by the terms of the ***Collective Bargaining Agreement*** between your Signatory Employer and your Service Employees International Union – CTW. Under some Agreements, you may have the option to choose between an indemnity medical plan or a Kaiser HMO Plan. If you are enrolled in an indemnity plan, the ***Schedule of Medical Benefits*** beginning on page 42 outlines the medical benefits available. If you are enrolled in a Kaiser Plan, you will receive an ***Evidence of Coverage*** directly from Kaiser.
- The rules for filing claims and the procedures to follow if you are dissatisfied with how a self-funded medical, prescription drug, vision, or dental claim is paid. However, if you are enrolled in a Kaiser Plan or one of the Pre-Paid Dental Plans, the rules for appealing a denial for service or a denial of payment for a service already received are in the ***Evidence of Coverage*** booklet you received directly from Kaiser or the Pre-Paid Dental Plan.
- Information about the administration of the program, and your rights under the Employee Retirement Income Security Act (ERISA) and other laws.

The Board of Trustees has the right to amend, change, or discontinue the types and amounts of benefits under this Plan, and the rules determining who is eligible for benefits. The Board of Trustees is granted the sole discretionary authority to make any and all determinations under the Plan, including who is eligible for benefits, the amount of benefits payable (if any) under any of the benefits funded directly by the Trust Fund, and the meaning and applicability of Plan provisions. Any such determinations shall be conclusive and binding on all parties having dealings with the Plan. No employer, trustee, or any representative of any employer or union is authorized to interpret this Plan on behalf of the Board of Trustees.

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

If you have questions about Plan benefits, please contact the Fund Office.

Sincerely,

BOARD OF TRUSTEES

INTRODUCTION

This Plan Document/Summary Plan Description (SPD) describes the self-funded medical, dental, vision benefits offered by California Service Employees Health and Welfare Trust Fund **(hereafter referred to as the "Fund").** The Plan described in this document is effective June 1, 2023, and replaces all other Plan Documents/SPDs previously provided to Plan participants.

While recognizing the many benefits associated with this Plan, it is also important to note that not every expense you incur for health care is covered by this Plan.

All provisions of this document contain important information.

IMPORTANT INFORMATION

California Service Employees Health and Welfare Trust Fund is committed to maintaining health care coverage for employees and their families at an affordable cost; however, because future conditions cannot be predicted, the Board of Trustees reserves the right to amend or terminate coverages at any time and for any reason. As the Plan is amended from time to time, you will be sent information explaining the changes. If those later notices describe a benefit or procedure that is different from what is described here, you should rely on the later information.

Be sure to keep this document, along with notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

This Plan is established under and subject to the federal law, Employee Retirement Income Security Act of 1974, as amended, commonly known as ERISA. The medical, vision and one of the dental options are self-funded with contributions from contributing employers and held in a Trust used to pay Plan benefits. An independent Claims Administrator pays benefits out of Trust assets. The life and accidental death and the prepaid dental plan are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document.

Foreign Language Assistance:

Si usted no entiende la información en este documento, por favor de ponerse en contacto con personal del departamento de Beneficios Administracion en (844) 492-9158.

Questions You May Have

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Fund Office at their phone number and address located on the Quick Reference Chart in this document. As a courtesy to you, staff may respond informally to oral questions; however, oral communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits. Your most reliable method is to put your questions in writing and fax or mail those questions to the Fund. In the event of any discrepancy between any information that you receive from the Fund Office orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

FOR HELP OR INFORMATION

When you need information, please check this document first. If you need further help, call the individuals listed in the following Quick Reference Chart:

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Fund Office/Claims Payor • Medical Claims and Appeals • Plan Benefit Information • Help understanding the covered wellness/preventive benefits payable by the Medical Plans • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC) • Information About COBRA Coverage • Adding or Dropping Dependents • Cost of COBRA Continuation Coverage • COBRA Premium payments • Second Qualifying Event and Disability Notification • COBRA Election Notice	**Northwest Administrators** 2323 Eastlake Ave East Seattle, WA 98102 (844) 492-9158 www.nwadmin.com
Membership Services	**Los Angeles Fringe Benefit Office** ***Membership Services*** 828 W. Washington Blvd. Los Angeles, CA 90015 (877) HWC-ASRV (492-2778) (213) 747-7551
PPO Providers • Medical Network Provider Directory (no charge) • Additions/Deletions of Network Providers • Preauthorization of inpatient admissions (for medical, mental health and substance abuse) • Appeals of UM decisions	**Anthem Blue Cross** **(800) 274-7767** Website for Online Network Provider Directory: www.anthem.com/ca **CAUTION:** Use of a **Non-PPO** hospital, facility or provider could result in you having to pay a substantial balance of the provider's billing. Balance billing occurs when a healthcare provider bills a patient for charges (other than copays, coinsurance, or deductibles) that exceed the Fund's payment for a covered service. **Your lowest out of pocket costs will occur when you use PPO providers**.
Prescription Drug Program for the PPO Plans administered by the Prescription Benefit Manager (PBM) • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Preauthorization of Certain Drugs	**OptumRx** Customer Service at (800) 797-9791 For preauthorization of Specialty Drugs, call 1-866-218-5445 or 1-855-4BRIOVA.

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
HMO • Medical claims and appeals	**Kaiser Foundation Health Plan** (800) 464-4000 ***Northern California Region*** 1950 Franklin Street Oakland, CA 94612 ***Southern California Region*** Walnut Center Pasadena, CA 91188-8516
Dental Plan • Dental Network Provider Directory (no charge) • Dental Claims and Appeals	**First Dental Health** 800.334.7244 www.firstdentalhealth.com
Prepaid Dental Plan • Dental Network Provider Directory (no charge) • Dental Claims and Appeals	**Delta Dental Plan** 12898 Towne Center Dr. Cerritos, LA 90703 (562) 403-4040
Prepaid Dental Plan (only offered to the Market Janitor group) • Dental Network Provider Directory (no charge) • Dental Claims and Appeals	**Liberty Dental Plan** www.libertydentalplan.com (888) 703-6999
Vision Plan • Vision Network and Provider Directory (no charge) • Vision Claims and Appeals	**Vision Service Plan** 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195
Life and AD&D Benefits • Life and AD&D Claims and Appeals	**ReliaStar Life Insurance Company** ***Customer Service*** Hours: 9:00am to 7:00pm ET Monday through Friday Tel. 877-886-5050 ***Claims*** Hours: 9:00am to 6:30pm ET Monday through Friday Tel. 888-238-4840 Fax. 877-788-6308
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**HIPAA Privacy Officer** Thomas Wagner Northwest Administrators 2323 Eastlake Ave East Seattle, WA 98102 206-329-4900 - phone 206-726-3209 - fax

ENROLLMENT IS REQUIRED

No Entitlement to Benefits Prior to Completing Enrollment

You must complete an enrollment form before you become entitled to benefits. You have no entitlement to benefits until you have completed an ***Enrollment Form*** and returned it to the Fund Office, even if you have worked sufficient hours to earn eligibility and your Employer has made the required contributions to the Trust Fund. ***Failure to complete and return an Enrollment Form will result in the loss of benefits***. Call the Fund Office or the Fringe Benefit Office for an ***Enrollment Form*** as soon as you begin working for a Signatory Employer.

If you have not completed an Enrollment Form, or if an additional form is needed, you may obtain one from the Fund Office. It is important that you notify the Fund Office in the event that:

- You change your home address.
- You wish to change your beneficiary (for life insurance).
- You become disabled.
- There is a change in your family status, i.e., marriage, birth of a child, adoption, death, divorce, dependent reaches the maximum age permitted under this plan etc.

The Plan requires that the name and Social Security Number of all Employees be reported to the Fund Office in order to enroll for benefits. Participants must also submit a marriage certificate in order to enroll a spouse. A birth certificate (or birth document that the Hospital provides) is required to enroll children, stepchildren, foster children or children for whom they are the legal guardian. Additional documentation may also be required. The Fund Office will provide the ***Enrollment Form*** so that you may enroll newly eligible family members or delete those no longer eligible.

Newborn and Newly Adopted Child

A newborn child will be eligible under the Plan from the date of birth and an adopted child will be eligible under the Plan from the date that the child is placed for adoption.

NOTE: If you are enrolled in Kaiser, an *Enrollment Form* must be requested from the Fund Office within 60 days of the date of birth or adoption. Failure to provide Kaiser with an ***Enrollment Form*** may result in difficulty in obtaining coverage from Kaiser for retroactive enrollment of more than two months.

If you are enrolled in the Indemnity Medical Plan, you must also complete an ***Enrollment Form*** and provide proper documentation before claims can be paid.

Choice of Medical Plans

Depending on the terms of the ***Collective Bargaining Agreement*** between the Union and your Signatory Employer, you **may** have two choices for your medical coverage – one of the indemnity medical plans described in this booklet or a Kaiser HMO Plan. You must live or work in the Kaiser service area to enroll in Kaiser. If you enroll in Kaiser, you must receive all of your health care from a Kaiser Health Plan facility inside the Kaiser service area, except where specifically noted to the contrary in the Kaiser ***Evidence of Coverage.*** Under the Kaiser plans, you pay a copay for each visit to the Kaiser Health Plan office and for prescription drugs. Some Kaiser Plans also may require a copay for hospital admissions, outpatient surgery and other services. The amount of your copay

depends on the Kaiser plan negotiated by the Union and your Employer. Please check your employer's ***Collective Bargaining Agreement*** to confirm your health plan.

The Kaiser plans are described in separate ***Evidence of Coverage*** brochures provided by Kaiser. To find out which Kaiser plan would apply to you, please call the Fund office. The Fund's group policy numbers with Kaiser are:

Kaiser Northern California - #26663 and #30303

Kaiser Southern California - #112490, #112491, #112492, and #230634

Employee Contributions May Be Required

Please note that mandatory payroll deductions may apply to either plan choice; please check your Collective Bargaining Agreement or call the Fund Office for further information.

Changing Health Plans

The Trust Fund has a rolling open enrollment program that allows you to change medical plans any time during the year; however, you must remain in the plan you select for a minimum of 12 months.

Exceptions:

- If you are enrolled in Kaiser and move out of the Kaiser service area, you may change to the indemnity medical plan without regard to previous changes provided that your particular Collective Bargaining Agreement allows for optional coverage). You and your family members must request enrollment in the same plan. Please call the Fund Office for an ***Enrollment Form*** if you want to change your medical and prescription drug plans or your dental plan. Any change in plans will be effective on the first day of the second calendar month after the Fund Office receives your enrollment forms.
- If you have a HIPAA Special Enrollment event that would otherwise allow a change in coverage.
- If your Employer is a **Racetrack Employer** (under either the SEIU United Service Workers West contract or Parimutuel Employees Union Local 280 – SEIU contract), you have an open enrollment period during the month of December of every year. Those employees who worked the minimum work hours from January through December of every year will qualify for coverage from February through January of the following year.

Please refer to your applicable Collective Bargaining Agreement regarding your Plan options.

ELIGIBILITY RULES (ACTIVE EMPLOYEES – BARGAINING UNIT)

Establishment and Maintenance of Eligibility – Active Employees

A person who is an Employee of an Employer with respect to whom contributions are made to the Fund for the maintenance of a health and welfare plan, shall become eligible, and remain eligible, in accordance with the terms of the ***Collective Bargaining Agreement*** in effect between their Employer and their Union.

Each ***Collective Bargaining Agreement*** provides for different rules and there **may be** a waiting period. ***After you meet any applicable waiting period***, there are generally two ways to maintain your eligibility.

Under some agreements, you must work a certain number of hours each month. Your employer should then make the required contribution to the Fund Office in the following month (the lag month). If the contribution is received, you will be eligible in the second month after you worked the required hours. For example, if you work the required hours in January and your Employer makes the required contribution in February, you will be eligible in March.

The other general procedure that is provided for in some agreements requires you to work a certain number of hours or man-days in a calendar year. If you work the required hours or man-days, you will be eligible during the following calendar year, provided your Employer timely makes the required monthly contribution.

Establishment and Maintenance of Eligibility – Retired Employees

A person shall become eligible as a Retired Employee if they meet the following requirements

- They must have been an Active Employee with a participating Employer of the California Service Employees Health and Welfare Trust Fund for at least 48 of the 60 months prior to their retirement; or
- If they are unable to meet the requirements of (i) above, then, in combination, they must have been, for at least 48 out of the 60 months prior to their retirement, an Active Employee with a participating Employer of the California Service Employees Health and Welfare Trust Fund or a participant in any other fund to which contributions are required under a collective bargaining agreement for services of the type performed by Active Employees with a participating Employer of the California Service Employees Health and Welfare Trust Fund and provided Employer contributions were made to the California Service Employees Health and Welfare Trust Fund on their behalf in the month(s) immediately prior to their retirement; **and**
- They must be a dues paying member or pay a service fee to the Union equal to the amount of dues required of retired members; **and**
- They must make continuous self-payments from the date coverage as an Active Employee was terminated, in the amount determined by the Board of Trustees; **and**
- They must apply within 31 days of their termination under the Health and Welfare Trust (unless the retiree qualifies for Special Late Enrollment, as described below); **and**
- They must be in receipt of a pension from at least one of the following Pension Plans: Affiliates Pension Fund, or SEIU National Industry Pension Fund.

Note: If a Retiree is eligible for coverage in Kaiser Senior Advantage as both a participant (through this Fund) and a dependent (through a spouse's plan). The Retiree

may choose whichever Kaiser plan best serves their needs. If they request enrollment in their spouse's Kaiser plan and later decide to request enrollment in this Fund's Kaiser plan they may do so within 60 days regardless of the reason their coverage terminated under their spouse's plan. They may also continue to purchase dental and vision coverage under this Trust while covered under their spouse's Kaiser plan.

Termination of Eligibility – Active Employee

An Active Employee's eligibility shall terminate on the earliest of the following dates:

- The first day of the month for which the required Employer contribution is not made on their behalf.
- On the day the plan of benefits provided in accordance with the terms of the Collective Bargaining Agreement in effect between their Employer and Union is terminated.
- Except as specifically provided for in this SPD, the first day of the month following any month in which they do not perform sufficient hours of covered employment to be eligible, even though an Employer contribution has been made on their behalf.

Termination of Eligibility - Retiree

A Retired Employee's eligibility shall terminate on the earliest of the following dates:

- The last day of the month for which the required dues or service fees have been paid.
- The last day of the month for which the required self-payment has been made.
- The last day of the month for which a benefit is payable to the Retired Employee from one of the above-referenced pension plans.
- The date on which this Plan is terminated by the Board of Trustees.

The eligibility of a spouse or Domestic Partner of a Retired Employee shall terminate on the date the Retired Employee's eligibility terminates, or the date they no longer qualify as a spouse or Domestic Partner.

Eligibility Rules for Dependents

Note: Not all Collective Bargaining Agreements provide for coverage of Dependents. In addition, Retirees are not allowed to enroll Dependent children.

If the ***Collective Bargaining Agreement*** provides for Dependent coverage, a Dependent becomes eligible at the same time an active Employee becomes eligible, or the date the Dependent is acquired (through marriage, birth, adoption or placement for adoption), if later, but only if they are included on an ***Enrollment Form*** filed with the Fund Office within 60 days of the date the Dependent is acquired. Appropriate documentation must be provided. Benefits cannot be paid until the new ***Enrollment Form*** is completed and returned to the Fund Office. Newborn eligible Dependents will be considered eligible from the date of birth. However, it is very important that you request a new ***Enrollment Form*** within 60 days of the birth of your baby.

For the purposes of these Eligibility Rules for Dependents, "Employee" means an eligible Active employee or Retiree. If your ***Collective Bargaining Agreement*** provides for Dependent coverage, you should include all Dependents who meet the eligibility requirements described below on your Enrollment Form.

Who are your Eligible Dependents?

Spouse

The legal spouse of an Employee or Retiree.

Domestic Partner

The Domestic Partner (see ***Glossary of Defined Terms***) of an Employee/Retiree. An initial application for coverage of a Domestic Partner must be submitted to the Fund Office declaring the intent to apply for Domestic Partner coverage. Eligibility for the Domestic Partner (Employee and Retiree) and any eligible children (active Employees only) of the Domestic Partner will begin on the first day of the month following the date that the required proof of Domestic Partnership, as described below, is submitted and approved by the Fund Office. The Employee may need to pay taxes on the value of the imputed income for the coverage to the Fund Office if the Domestic Partner does not qualify as a tax dependent.

Within 30 days of the date of the filing of the initial application, either a notarized Affidavit of Domestic Partnership (available from the Fund Office) or a Certificate of Domestic Partnership issued by the California Secretary of State must be filed with the Fund Office. If a Certificate issued by the Secretary of State is **not** submitted as proof of the formation of the Domestic Partnership, then within 90 days of submission of the notarized Affidavit, additional documentation must be provided to the Fund Office, including at least two of the following: proof of joint bank account; proof of joint lease/mortgage of mutual residences, joint billing statements for e.g. gas, electric, telephone; joint credit card accounts; joint loan agreements; joint car ownership or other titles or deeds which are jointly held.

Dependent Child(ren)

A Dependent Child is anyone who has one of the relationships with the Employee **(children of eligible Retirees are not covered)** listed below, and who is under the age of 26 (whether married or unmarried):

- The Employee's natural children;
- Legally adopted children. Children placed for adoption will be covered as of the date the Employee first becomes legally obligated to provide full or partial support of the child; however, if the child's coverage will cease if the adoption does not proceed and the Employee's legal obligation to provide full or partial support terminates.
- Stepchildren or foster children;
- Children of your Domestic Partner (for active Employee's only); and
- Children for whom the Employee has been appointed legal guardian;
- A child older than the limiting age of 26 who is prevented from earning a living because of mental or physical disability (provided the disabled child was so disabled and eligible as a Dependent at the time they reached the limiting age of 26), and are solely dependent upon the Employee for support. Medical evidence of the child's dependence and incapacity must be filed with the Fund Office within 31 days after attaining the limiting age and periodically thereafter, as requested by the Fund Office.
- A child required to be recognized under a Qualified Medical Child Support Order (QMCSO) under ERISA Section 609(a)(2)(A). If the Fund Office receives such an order, it will be referred to Fund Counsel to determine if the qualified medical child support order is "Qualified." Please contact the Fund Office for a copy of this Plan's QMCSO procedures, free of charge.

A spouse of a Dependent Child (e.g. son-in-law/daughter-in-law) or child of a Dependent Child (e.g. employee's grandchild) are not eligible for coverage under the Plan unless proof of legal guardianship is provided.

Note regarding possible Tax Issues

If you enroll a child in the Plan who does not meet the definition of "Dependent" as a "qualifying child" or "qualifying relative" as outlined in **Sections 152(c) or (d) of the Internal Revenue Code**, you may be responsible for paying income tax on the fair market value of the benefits provided to that child. That value of the benefits is known as taxable "imputed income." This situation may arise if you enroll a child of a Domestic Partner, or if you enroll a child for whom you are the legal guardian.

Additionally, where a state law definition of "Dependent" does not match with the federal law definition of "Dependent", your employer must include in your gross income the fair market value of the coverage provided to an adult child.

The above situations may increase both your taxable income and your tax liability. You should consult with a tax specialist on these matters..

Qualified Medical Child Support Orders (QMCSO)

This Plan will provide benefits in accordance with a **Qualified Medical Child Support Order** or a **National Medical Support Notice**. In this document, the term QMCSO is used for and includes compliance with a National Medical Support Notice. According to federal law, a Qualified Medical Child Support Order is a judgment, decree or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO typically requires that the Plan recognize the child as a dependent even though the child may not meet the Plan's definition of dependent.

If the Plan has determined that an order is a valid QMCSO, it will accept enrollment of the alternate recipient for the period of coverage outlined in the QMCSO. The Dependent will be added as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions.

For additional information or to request a copy of the procedures for administration of QMCSOs (free of charge), contact the Fund Office.

Special Enrollment

If you are declining enrollment for yourself or your dependents (including your spouse) because of other health insurance or group health plan coverage, you may be able to enroll yourself and your dependents in this plan if you or your dependents lose eligibility for that other coverage (or if the employer stops contributing toward your or your dependents' other coverage). However, you must request enrollment within 60 days after your or your dependents' other coverage ends (or after the employer stops contributing toward the other coverage).

In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents. However, you must request enrollment within 60 days after the marriage, birth, adoption, or placement for adoption.

You and/or your Dependents may also enroll in this Plan if you or your Dependents have coverage through Medicaid or a State Children's Health Insurance Program (CHIP) and you or your Dependents lose eligibility for that coverage or become eligible for a premium assistance program through Medicaid or CHIP. However, you must request enrollment within 60 days after the Medicaid or CHIP coverage ends or is determined to be eligible for such assistance.

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

Note: There is an exception to the above rules for Retirees who are eligible for coverage in Kaiser Senior Advantage as both a participant (through this Fund) and a dependent (through a spouse's plan). Such a retiree may choose whichever Kaiser plan best serves their needs. If they request enrollment in their spouse's Kaiser plan and later decide to request enrollment in this Fund's Kaiser plan they may do so within 60 days regardless of the reason their coverage terminated under their spouse's plan. They may also continue to purchase dental and vision coverage under this Trust while covered under their spouse's Kaiser plan.

In addition, a special Open Enrollment period to add dependents outside the periods specified above may be held from time to time at the sole discretion of the Board of Trustees.

Termination of Eligibility for Dependents

A Dependent's eligibility will terminate on the earlier of the following dates:

- The date he or she no longer meets the Plan's definition of a Dependent (such as the end of the month after a Dependent child turns age 26); or
- The date eligibility terminates for the Employee/Retiree; or
- With respect to a Dependent spouse, on the date of entry of a final decree of dissolution of marriage or legal separation with respect to that spouse; or
- With respect to a Dependent child, on the date the eligible Employee Retires; or
- With respect to a Domestic Partner and any eligible Dependent children of the Domestic Partner, the date the Domestic Partnership is terminated, either upon submission of a Statement of Termination of domestic partnership signed by either party, or as determined by the Board of Trustees. Coverage will also be terminated upon failure of the Employee to pay the required taxes on the value of the imputed income for the coverage; or
- The date the Plan terminates.

You are responsible for notifying the Fund Office immediately when a Dependent no longer meets the eligibility requirements of the Plan.

Retroactive Cancellation of Coverage

In accordance with the requirements in the Affordable Care Act, the Fund will not retroactively cancel coverage **except** in cases of fraud or intentional misrepresentation of a material fact after 30-day advance written notice is given.

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

Extension for Total Disability

Extension of Medical Benefits only

If you or your Dependent is Totally Disabled on the date your or your Dependent's coverage terminates, benefits will be extended at no charge solely for covered medical expenses incurred by you or your Dependent as the direct result of the Total Disability. Coverage will be extended until the earliest of the following:

- The date the individual ceases to be Totally Disabled; or
- The date the individual becomes eligible under another health insurance plan (such as having access to a spouse's plan) or Medicare (including Medicare Part A or Part B or both). Please note this termination provision will not apply to a Dependent under age 26 who becomes eligible for other employer coverage through their own employment or a spouses employment; or
- The end of a 12-month period from the date the individual's coverage terminated under this Plan.

Any claim for this extension must be filed within 90 days of termination.

NOTE: This extension provides coverage only to the disabled individual and only for medical charges directly related to the disabling Injury or Illness. You have a choice between electing this extension of medical benefits or COBRA continuation coverage. If you elect the extension, you will not be eligible to elect either COBRA Continuation or Conversion coverage when this benefit expires.

Extension of Eligibility (for Active Participants only)

If your coverage would terminate because you are unable to work due to disability, you may qualify for extended medical coverage for you and your Dependents for a limited period of time at no cost. To qualify for this extension, you must provide the Fund Office with written certification of your disability from your Physician and you must have been eligible under the Trust Fund when you became disabled. **The written certification of your disability from your Health Care Practitioner (i.e., the completed Work Status Report) must include a medical diagnosis.**

The length of the eligibility extension depends on the amount of time you were eligible under the Trust Fund before becoming disabled, as shown in the following chart:

If you were previously eligible as an active Employee for:	Fund will pay your premium during disability for consecutive months starting with the first month of lost eligibility for:
At least 12 consecutive months but less than 24 months immediately prior to becoming disabled	**3 months** of extended coverage
At least 24 consecutive months immediately prior to becoming disabled	**6 months** of extended coverage

Note: **Racetrack Employees** have additional disability benefits under their ***Collective Bargaining Agreement***. Please refer to your contract for more information on this benefit and the qualifying rules.

Previous months of disability extension or COBRA coverage do not qualify as "active coverage" for purposes of satisfying the qualifications above.

If you qualify for disability extension coverage of up to 3 or 6 months but use fewer months than your length of continuous coverage otherwise qualifies them for, the unused months of disability extension coverage could be applied in the future for the same or a different disability provided there is no break in coverage or intervening COBRA coverage. If you return to work and regain the minimum 12 consecutive months of active coverage based on employer contributions (or contributions pursuant to FMLA), you would then re-qualify for a new period of disability extension coverage, provided that all other qualifications are met.

Dual Coverage: Employee Working for Two Contributing Employers

If an Employee works for two different contributing employers who pay two separate contributions to the Trust Fund on his or her behalf, benefits will be coordinated for that individual, up to the maximum amounts provided under the Plan.

An Employee eligible under this provision may also claim dual coverage benefits for his or her eligible Dependents. However, in no event will the total amount of benefits payable exceed 100% of the actual eligible charges incurred by an individual.

Surviving Spouse of a Retiree - Continuation of Coverage

If termination of the Dependent Spouse's coverage was caused by the death of the Retiree, the Spouse may continue to be eligible provided that the Spouse applies and makes the necessary self-payments in accordance with the rules established by the Board of Trustees. Contact the Fund Office for further information, including the self-payment amount.

Benefits Provided

Active Employees

Depending upon the terms of the Collective Bargaining Agreement in effect between their Employer and the Union, an Active Employee and their Dependents may be eligible for one or more of the following Plan benefits:

- Medical benefits;
- Life insurance benefits;
- Dental benefits;
- Prescription drug benefits; and/or
- Vision benefits.

You must reference your ***Collective Bargaining Agreement*** to determine if you are eligible for each type of benefit and, if so, your exact level of benefits.

Retirees

Upon determination of the Retired Employee's eligibility, the Retired Employee may elect to continue the benefits provided to them while an Active Employee (with the exception of life insurance and accidental death and dismemberment benefits) by making the required self-payments to the Fund. A Retired Employee may elect to continue:

- Medical and prescription drug coverage only; or

- Medical and prescription drug coverage plus dental and vision, but only if dental and vision coverage were provided to them as an Active Employee.

Note: Dependent children of eligible Retirees are not eligible for coverage.

Dental and vision coverage may not be selected without medical and prescription drug coverage.

If the Retired Employee cancels one of the coverages originally selected it will have the effect of canceling all other benefits. Once benefits have been terminated, the Retiree and their spouse may not re-enroll for Retiree coverage, unless it follows a return to work as an Active Employee.

When You Become Eligible for Medicare

When you (the Retiree) or your Spouse (or Domestic Partner) become eligible for Medicare, whether due to age or disability, **you must enroll in both Part A and Part B of Medicare and pay the required premiums for Part B.** Failure to do so will result in much higher out-of-pocket costs to you. The Trust Fund will only pay the amount it would have paid had your claims been submitted to Medicare and Medicare had paid the claim first.

If you are enrolled in Kaiser, you must assign your Medicare Part A and Part B benefits to Kaiser and enroll in the Kaiser Senior Advantage Plan.

IMPORTANT NOTE FOR MEDICARE-ELIGIBLE RETIREES

If you and/or your spouse/domestic partner are eligible for Medicare, you must enroll in Medicare Part A and Part B. When you retire, Medicare will become the primary payer for your medical expenses and this Plan will pay benefits after Medicare pays its portion of the bill.

Benefits that are paid for by this Plan for Medicare-eligible Retirees/Dependents are reduced by the amounts payable under Medicare Parts A (Hospital), and B (Professional services). This reduction will apply even if the Medicare-eligible Retiree or Dependent is NOT enrolled in Medicare Part A or B. Therefore, **if you are retired and you and/or your spouse/domestic partner are Medicare-eligible, you should enroll in Medicare Parts A and B in order to receive the maximum amount of benefits to which you are entitled under this Plan.**

Caution regarding enrollment in a Medicare prescription drug plan

You may enroll in ONE individual prescription drug plan approved by Medicare and keep your Indemnity Prescription Drug Benefits from the California Service Employees Health and Welfare Trust Fund. You will need to pay the Part D premium out of your own pocket. If you are an Active Employee or the Dependent of an Active Employee, the Trust Fund will pay claims primary and your individual plan will pay secondary. If you are a Retiree or the Dependent of a Retiree, your individual plan will be the primary payer and the Trust Fund will pay secondary.

However, if, after you retire, you DROP your Indemnity Prescription Drug Plan and enroll in an individual prescription drug plan approved by Medicare, you will not be allowed to later re-enroll in the Indemnity Prescription Drug Plan offered by the Trust Fund.

It has been determined that the prescription drug coverage outlined in this document is "creditable." "Creditable" means that the value of this Plan's prescription drug benefit is, on average for all plan participants, expected to pay out as much as the standard Medicare Part D Prescription Drug Plan (PDP) coverage will pay.

Active Employees and Dependents: Because this Plan's prescription drug coverage is as good as Medicare, you do not need to enroll in a Medicare Part D Prescription Drug Plan (PDP) in order to avoid a late penalty under Medicare. You may wait until you retire to enroll in a Medicare Part D Plan. After you retire, there is a special Medicare special enrollment period where you will be allowed to elect a Medicare Part D Plan if you want.

Special Caution for Retirees Enrolled in Kaiser Senior Advantage: If you are enrolled in Kaiser Senior Advantage and you enroll in an individual prescription drug plan approved by Medicare, the Centers for Medicare and Medicaid Services (CMS) will **AUTOMATICALLY DISENROLL YOU FROM KAISER SENIOR ADVANTAGE** for both prescription drugs and medical benefits. You will have to pay a much higher cost to continue your medical coverage.

Family and Medical Leave Act

The Family and Medical Leave Act of 1993 (FMLA) provides that in certain situations you may be entitled to take up to 12 weeks of unpaid leave during any 12-month period (in some cases, up to 26 weeks), and that in such situations the Contributing Employer is required to continue coverage. Additional leave may be available if the need for leave is related to call up into the armed services or to care for a family member who was injured while on active duty in the armed services. Determination as to whether a leave of absence is qualified shall be made by the Contributing Employer, and is subject to review by the Board of Trustees. If requested, you must submit proof acceptable to the Trust that the leave is in accordance with FMLA provisions.

In the event that both spouses are covered under the Plan as active Employees, and are employed by the same Employer, the FMLA continued coverage may not exceed a combined total of 12 weeks if the purpose of the FMLA leave is:

- The birth of a child, or to care for a child after birth
- Placement for adoption or foster care of a child, or to care for a child after placement for adoption or foster care; or
- To care for a parent with a serious health condition.

If you become eligible for: (a) FMLA coverage due to your own disability, (b) Racetrack Federation Employees disability program and (c) this Plan's Extended Benefits for Disability, the FMLA leave is exhausted first and, if you are a Racetrack employee, then the Federation's disability program is to be exhausted next and then the Trust Fund's Extended Benefits for Disability will be applied last. You may also be eligible to elect COBRA Continuation Coverage following the day FMLA continuation is exhausted.

Continuation of coverage under FMLA ends on the earliest of:

- The day you return to work;
- The day you notify your Contributing Employer that you will not be returning to work (if you do not return to work at the end of the FMLA leave, your Employer may require you to reimburse contributions made to the Plan on your behalf during the leave);

- The day coverage under the Plan would otherwise end; or
- The day after coverage has been continued under FMLA for 12 (or, in some cases, up to 26) weeks.

You should contact your Contributing Employer to find out more about Family or Medical Leave and the terms on which you may be entitled to it. The calculation of the FMLA time period is the responsibility of the Contributing Employer with review by the Board of Trustees.

Continued Coverage While in Uniformed Service – Active Employees

What to Do if You are Called Up for Military Service

If you perform service in the Uniformed Services of the United States, federal law provides certain rights to continued coverage under this Plan. You may choose to freeze your eligibility status until the period of service ends or continue coverage for up to a maximum of 24 months from the date that service commences.

The terms "Uniformed Services of the United States" and/or "Uniform Services" mean the Armed Services (including the Coast Guard), the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or emergency.

If you (and your eligible Dependents) are eligible for benefits as of the date of your entry into service in the Uniformed Services of the United States, and your absence is due to a uniformed services leave of less than 31 days, coverage will be continued at no cost to you. You will be credited with hours necessary to keep coverage in effect as if you had worked in covered employment with a Contributing Employer during the period of service.

If you (and your eligible Dependents) are eligible for benefits as of the date of your entry into service in the Uniformed Services of the United States, and your absence is due to a uniformed services leave of 31 days or more, you or your eligible Dependent(s) may elect to continue coverage (under either COBRA or USERRA) by self-payment under the provisions of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA).

A premium for continuation coverage under USERRA will be the same as the COBRA rates established by the Plan and will be payable in monthly installments. The maximum length of USERRA continuation coverage is the lesser of:

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

If you do not elect to continue coverage under either COBRA or USERRA, your eligibility status will be frozen as of the date of entry into Uniformed Services. Eligibility for coverage for you and any eligible Dependents will terminate at the end of the month in which you entered into Uniformed Services.

Note: The Election and Notice Requirements for USERRA are generally the same as for COBRA Continuation Coverage. However, USERRA is an alternative to COBRA and therefore, either COBRA or USERRA continuation coverage can be elected. Please

refer to the COBRA section of this booklet for a description of your COBRA rights and responsibilities.

Reinstatement of Eligibility following Uniformed Service

If you were eligible for benefits on the date of your entry into the Uniformed Services of the United States, and upon completion of service you notify your Contributing Employer or your Local Union of your intent to return to employment as specified in USERRA, you will reinstate eligibility (eligibility will pick up as it was the day before you entered into Uniformed Services). If you are re-employed with a Contributing Employer in accordance with USERRA provisions, you are entitled to coverage under the Plan and all rights and benefits under the Plan that you would have attained if you remained continuously employed with a Contributing Employer.

No benefits will be provided by the Plan for Illnesses or Injuries determined by the Department of Veterans Affairs to have been incurred in or aggravated during performance of duties in the Uniformed Services.

CONTINUATION OF COVERAGE UNDER FEDERAL LAW (COBRA)

IMPORTANT: This section serves as a notice to summarize your rights and obligations under the COBRA continuation coverage law. It is provided to eligible Employees and Dependent Spouses of Retirees and is intended to inform them (and their covered dependents, if any) in a summary fashion of their rights and obligations under the continuation provisions of the federal law. Since this is only a summary, actual rights will be governed by the provisions of the COBRA law itself. It is important that you and your spouse take the time to read this notice carefully and be familiar with its contents.

Other Health Coverage Alternatives to COBRA

You may have other options available to you when you lose group health coverage. For example, you may be eligible to buy an individual plan through the Health Insurance Marketplace. By enrolling in coverage through the Marketplace, you may qualify for lower costs on your monthly premiums and lower out-of-pocket costs. Additionally, you may qualify for a 30-day special enrollment period for another group health plan for which you are eligible (such as a spouse's plan), even if that plan generally doesn't accept late enrollees.

For California residents, see www.coveredca.com. For non-California residents see your state Health Insurance Marketplace or www.healthcare.gov).

Who Is Entitled to COBRA Continuation Coverage

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

A "Qualified Beneficiary" is any Employee or the Spouse or Dependent Child of an Employee (including a child who is receiving benefits under the Plan because of a Qualified Medical Child Support Order), who was covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage.

Please note: while eligible Domestic Partners and the eligible children of Domestic Partners who lose eligibility under Plan are not eligible for federal COBRA benefits, these individuals may continue Plan coverage through self-payment for a limited period-of-time under a COBRA-like benefit provision as described on page 29.

Please note: When you retire, you (the Employee) are offered a choice between electing a temporary continuation of your active group health coverage ("COBRA Continuation Coverage") or electing Retiree coverage. If you elected the Fund's Retiree coverage, you have no further COBRA continuation rights. However, your covered Dependent Spouse may experience a COBRA Qualifying Event as described in this section.

Qualifying Events

If one of the following events (known as a Qualifying Event) occurs and results in a loss of coverage, you and your eligible Dependents have the right to temporarily continue health coverage that was in effect at the time of the Qualifying Event under a federal law known as "COBRA". COBRA Continuation Coverage is available through the California Service Employees Health and Welfare Trust Fund for those who qualify. To receive this

continuation coverage, you must pay monthly premiums to the Fund. The following are COBRA Qualifying Events:

- Reporting by your Employer(s) of less than the minimum required work hours for a month to the Fund on your behalf (insufficient work hours making you ineligible for coverage);
- The loss of employment with a participating Employer (including retirement);
- Employee's divorce or legal separation causing Spouse's loss of status as a Dependent;
- Employee's death; or
- The Dependent child's loss of status as a Dependent under this Plan.

Special Enrollment Rights

You have special enrollment rights under federal law that allow you to request special enrollment under another group health plan for which you are otherwise eligible (such as a plan sponsored by your Spouse's employer) within 30 days (or as applicable 60 days) after your group health coverage ends because of the Qualifying Events listed in this chapter. The special enrollment right is also available to you if you continue COBRA for the maximum time available to you.

Duration of COBRA Coverage

COBRA coverage can continue for up to 18, 29 or 36 months, depending on the COBRA Qualifying Event. The information below is summarized in the COBRA Summary of Events Reference Chart below.

- ***18 Months*** - You and/or your Dependents can continue coverage for up to 18 months from the date of the Qualifying Event if you would otherwise lose coverage because less than the minimum work hours were reported for a month on your behalf or your employment has been terminated. (Note that if the reason for the reduction in hours is entry into military service, an additional six months of coverage is available if your military service exceeds 18 months.)
- ***29 Months*** – An 18-month coverage period can be extended to a total of 29 months if you or your Dependent becomes disabled (as determined by the Social Security Administration) before or during the first 60 days of COBRA coverage. See ***"Extended COBRA Coverage in Cases of Disability."***
- ***36 Months*** - Each of the other above-listed Qualifying Events (Employee dies, divorce or legal separation, or a Dependent child loses status as a Dependent) entitles your Dependents to 36 months of coverage from the date of the Qualifying Event. (In the case of a child's losing Dependent status, only the affected child is eligible for 36 months of coverage.)

Summary of Events and Duration of COBRA coverage

Qualifying Event Causing Loss of Coverage	Qualified Beneficiary	Maximum Continuation Period
Insufficient work hours	You, your Spouse and Dependent children	18 months after date of Qualifying Event*

Qualifying Event Causing Loss of Coverage	Qualified Beneficiary	Maximum Continuation Period
Termination of your employment (including retirement)	You, your Spouse and Dependent children	18 months after date of Qualifying Event*
Your death	Your Spouse and Dependent children	36 months after date of Qualifying Event
Your divorce or legal separation	Your Spouse and Dependent children	36 months after date of Qualifying Event
Your child's loss of Dependent status under Plan	Effected Dependent if covered under Plan	36 months after date of Qualifying Event

- If you or one of your eligible Dependents is disabled, COBRA Continuation Coverage may continue for the disabled person and eligible family members for up to 29 months. A higher premium will be charged for the additional 11 months of coverage.
- If a second Qualifying Event that would result in a 36-month continuation coverage period occurs within the first 18-month period, COBRA Continuation Coverage for Dependents may be extended for up to a maximum of 36 months from the date of the first Qualifying Event.

Extended COBRA Coverage in Cases of Disability

If you and/or your Dependents are entitled to COBRA coverage for an 18-month period, that period can be extended for an eligible person who is determined to be entitled to Social Security Disability Income benefits, and for any other eligible family members, for up to 11 additional months (for a total of 29 months) if all of the following conditions are satisfied:

- The disability occurred on or before the start of COBRA coverage or within the first 60 days of COBRA coverage.
- The disabled person receives a determination of entitlement to Social Security Disability Income benefits from the Social Security Administration.
- The Participant, the disabled person or other family member notifies the Fund Office that the determination was received. See "***Your Duty to Notify the Fund Office***" below for notification deadlines.

The premium for the additional 11 months will be approximately 50% higher than the premium for the initial 18 months of COBRA coverage.

Extended COBRA Coverage if a Second Qualifying Event Occurs

If, during an 18-month period of COBRA Continuation Coverage resulting from insufficient work hours or termination of employment, the Employee dies, divorces, or if a covered child ceases to be a Dependent child under the Plan, the maximum COBRA coverage period for the affected Spouse and/or child is extended to 36 months from the date of the first Qualifying Event.

If you marry after the first Qualifying Event, this extended period of COBRA coverage is not available to your new spouse. However, this extended period of COBRA coverage is available to any children born to, adopted by, or placed for adoption with the Participant during the 18-month period of COBRA coverage. See "***Your Duty to Notify the Fund***

Office" below regarding your responsibility to notify the Fund Office that a second qualifying event has occurred.

Can I enroll in Medicare instead of COBRA Continuation Coverage after my Group Health Plan Coverage Ends?

In general, if you don't enroll in Medicare Part A or B when you are first eligible because you are still employed, after the Medicare initial enrollment period, you have an 8-month special enrollment period[1] to sign up for Medicare Part A or B, beginning on the earlier of:

- The month after your employment ends; or
- The month after group health plan coverage based on current employment ends.

If you do not sign up for Medicare during the 8-month special enrollment period after you stop working, you will have to wait until the next general enrollment period.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage.

If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.

For more information visit https://www.medicare.gov/medicare-and-you.

Medicare Entitlement

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

Cost of Continuation Coverage – Benefits That May Be Continued

COBRA Continuation Coverage is available only at your own expense. If you or your Dependents elect to continue coverage, the full cost, plus a 2% administrative charge, will be charged (in the case of an extension due to disability, it is the full cost plus 50%). You may only elect those benefits for which you were eligible under the terms of your

[1] https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

Collective Bargaining Agreement on the day preceding the Qualifying Event. Assuming you were eligible for all benefits, you may elect to continue medical and prescription drug coverage only (Core Coverage) or medical, prescription drug, vision and dental coverage (Core Plus Coverage). Dental and vision coverages do not have to be continued; however, you may not continue one of these benefits without the other. COBRA coverage does not include death, AD&D or disability coverage.

Paying for COBRA Coverage

The Fund Office will notify you of the cost of the coverage at the time you receive your notice of entitlement to COBRA coverage and of any monthly COBRA premium amount changes. The cost of COBRA Continuation Coverage may be subject to future increases during the period it remains in effect.

For Monthly Payments, What If The Full COBRA Premium Payment Is Not Made When Due?

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

- **If there is a significant shortfall,** then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made.
- **If there is not a significant shortfall**, the Fund Office will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall.
- If the shortfall is paid in the 30-day time period then COBRA continuation coverage will continue for the month in which the shortfall occurred.
- If the shortfall is not paid in the 30-day time period then COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in a mid-month termination of COBRA coverage).

Grace Period

There will be an initial grace period of 45 days to pay the first premium due starting with the date COBRA coverage was elected. If this first payment is not made when due, COBRA coverage will not take effect. After the first payment, subsequent payments are due on the first day of each month. There will be a grace period of 30 days to pay the monthly premium payments. If payment of the amount due is not made by the end of the applicable grace period, your COBRA coverage will terminate.

If you make a payment later than the first day of the coverage month to which it applies, but before the end of the grace period for that month, your benefits under the plan will be suspended as of the first day of the coverage month and then retroactively reinstated (going back to the first day of the coverage month) when the payment is received. This means that any claim you submit for benefits while your coverage is suspended may be denied and may have to be resubmitted once your coverage is reinstated.

IMPORTANT

NWA sends monthly payment reminders for COBRA premium payments. However, you are ultimately responsible for making sure that timely COBRA premium payments are made to the Fund Office.

Your Duty to Notify the Fund Office

You or your dependents are responsible for providing the Fund Office with timely notice of the following qualifying events **within 60 days of the date the following events occur**:

- Your divorce or legal separation from your spouse,
- Loss of dependent status by a child, or
- The occurrence of a second qualifying event while your dependents are in an 18-month COBRA continuation period (see "***Extended COBRA Coverage If a Second Qualifying Event Occurs***" above).

You must also provide the Fund Office with timely notice when:

- You and your dependents have experienced a Qualifying Event entitling you to COBRA Continuation Coverage with a maximum duration of 18 months and one of you is determined by the Social Security Administration to be disabled, or
- The Social Security Administration determines that the person is no longer disabled.

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

How to Notify the Fund Office

Notice of any of the five situations listed above must be given to the Fund Office in writing. You must send a letter to the Fund Office containing the following information:

- Name of the Qualified Beneficiary,
- The Participant's name and ID number or social security number,
- The event for which you are providing notice and the date of the event (for example, the date of a dependent child's 26th birthday), and
- A copy of the final marital dissolution (or legal separation) if the event is a divorce (or legal separation),

If you have any questions about how to notify the Fund of one of these events, please call the Fund Office.

Where to Send Your Notice

Notice of Qualifying Events should be sent to the Fund Office at the following address:

California Service Employees Health and Welfare Trust Fund
Attn: COBRA Department
2323 Eastlake Ave East
Seattle, WA 98102

When to Notify the Fund Office

If you are providing notice of a divorce or legal separation, a Dependent child losing eligibility for coverage, or a second Qualifying Event, you must send the notice no later than 60 days after the date of the qualifying event.

If you are providing notice of a Social Security Administration determination of disability, notice must be sent no later than the end of the first 18 months of continuation coverage. Your COBRA rights will be forfeited if you do not notify the Fund Office within these time frames.

If you are providing notice of a Social Security Administration determination that you or your dependent is no longer disabled, notice must be sent no later than 30 days after the date of the determination by the Social Security Administration that you (or your Dependent) are no longer disabled.

Who Can Notify the Fund Office

Notice may be provided by you, your Dependents, any representative acting on behalf of you, or your Dependents. Notice from one individual will satisfy the notice requirement for all related qualified beneficiaries affected by the same qualifying event. For example, if your spouse notifies the Fund Office that your child has ceased to meet the definition of a dependent under the Plan, that single notice would satisfy the notification requirement.

Electing Continuation Coverage

The Fund Office will determine when your Employer reports less than the minimum required work hours to the Fund on your behalf. In the event of your death, the Fund Office will notify your dependents of their COBRA rights when it becomes aware of the death through notification from an employer, a union officer, in the course of administering the Plan's benefits, or otherwise.

The Fund Office will send you a notice if you have not met the eligibility requirements in a month. This notice will tell you when your eligibility terminates and ask you to complete and return the form if you want self-pay COBRA Continuation Coverage beyond the termination of your eligibility. Even if you think you will be returning to work and will not need COBRA Continuation Coverage, it is very important that you return the election form to the Fund Office within 60 days.

After receiving your notice of any other qualifying event, the Fund Office will send you a notice of your right to choose continuation coverage with an election form, or, if you do not qualify for continuation coverage, a Notice of Unavailability of COBRA Coverage. These notices will be sent within 14 days of the date the Fund Office receives your notice.

YOU MUST SIGN AND RETURN THE ELECTION FORM TO THE FUND OFFICE NO LATER THAN 60 DAYS AFTER THE DATE OF YOUR LOSS OF ELIGIBILITY OR THE DATE OF THE COBRA NOTICE FROM THE FUND OFFICE (WHICHEVER IS LATER) OR YOU WILL NOT BE ELIGIBLE FOR COBRA CONTINUATION COVERAGE.

COBRA rights will be forfeited if you or your Dependents do not file the COBRA election forms within this 60-day period. If you do not choose continuation coverage, your health insurance coverage will end. However, your Spouse and/or your eligible Dependents may elect continuation coverage, even if you do not.

Your initial continuation coverage will be identical to coverage provided to similarly situated Participants under the Plan on the day prior to the Qualifying Event, although it may be modified if coverage changes are allowed for active Employees and/or Dependents.

Adding New Dependents

If, while you are enrolled for COBRA Continuation Coverage, you marry, have a newborn child, have a child placed with you for adoption, or assume legal guardianship of a child, you may enroll that Spouse or child for coverage for the balance of the period of your continuation coverage, by sending a completed ***Enrollment Form*** to the Fund Office within 30 days after the birth, marriage or placement for adoption or legal guardianship.

Any Qualified Beneficiary can add a new Spouse or child to his or her COBRA Continuation Coverage, but the only newly added family members who have the rights of a Qualified Beneficiary, such as the right to stay on COBRA Continuation Coverage longer if a second Qualifying Event occurs, are the natural, adopted or legal guardianship children of the former Employee.

Special enrollment for the balance of your COBRA period is also allowed for dependents who lose other coverage. For this to occur:

- Your Dependent must have been eligible for COBRA coverage on the date of the qualifying event but declined when enrollment was previously offered because he or she had coverage under another group health plan or had other health insurance coverage,
- Your Dependent must exhaust the other coverage, lose eligibility for it, or lose employer contributions to it, and
- You must enroll that dependent by sending an ***Enrollment Form*** to the Fund Office within 30 days after the termination of the other coverage or contributions.

Termination of COBRA Continuation Coverage

COBRA Continuation Coverage will terminate at the end of the maximum continuation period allowed (18, 29, or 36 months, as applicable). COBRA Continuation Coverage will terminate before the end of the 18, 29, or 36-month period upon the occurrence of any of the following events:

- You or your Dependents fail to remit the required premium payments in full and on time (within 45 days following the submission of the initial COBRA election form and including the cost of coverage retroactive to the first day your coverage would have otherwise terminated, or within 30 days following the due date for subsequent monthly payments);
- You or your Dependents become covered under any other group medical plan after the date you elect COBRA coverage;
- You or your Dependents become entitled to Medicare Part A or Part B after the date of your COBRA election;
- The Fund ceases to provide any group health plan to any participating Employer;
- The date the participating Employer ceases to participate in the Plan if that Employer begins to participate in another group health plan;

- You or your Dependents have continued coverage for additional months due to a disability and there has been a final determination by Social Security that you or your Dependents are no longer disabled; or
- During an extension of the maximum COBRA coverage period to 29 months due to the disability of a Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled.

COBRA Continuation Coverage will terminate at the end of the month following the events listed above. If COBRA coverage is terminated before the end of the maximum period of coverage, the Fund Office will send you a written notice as soon as practicable following its determination that continuation coverage will terminate.

Keeping the Fund Office Notified

If you have changed marital status, or you (or your Spouse or other Dependents) have changed addresses, please contact the Fund Office. Please let the Fund Office know of any Qualifying Event even if your Employer is otherwise required to give notice to the Fund Office.

IMPORTANT NOTE: Should federal or state law alter the provisions of COBRA in existence at the time this ***Summary Plan Description*** is printed, participants will be advised of these modifications as required.

Post-COBRA Coverage Under an HMO - California COBRA Law

If you are a COBRA participant enrolled in a Kaiser HMO, California law has a provision that affects the length of time you may continue coverage. This law applies only to your HMO medical coverage or other benefits that are insured but not to any health care benefits that are self-funded by the Trust Fund and usually available under COBRA. Payments beyond the federal COBRA period are made directly to the HMO or other insurer.

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 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.

Conversion to Individual Coverage

At the end of the COBRA Continuation Coverage period, you or your eligible Dependents may enroll in any individual conversion plan offered by an HMO as described in the HMO's Evidence of Coverage brochure, provided you were enrolled in the HMO before your continuation coverage ended.

You may also be eligible to purchase individual conversion benefits for dental, vision, and life insurance. You should refer to the ***Evidence of Coverage*** provided by the insurer of each of these benefits.

Note: You also have the option to purchase individual conversion coverage from the HMO instead of COBRA coverage, but only if you were enrolled in the HMO when your Trust Fund coverage ended.

Check your HMO's ***Evidence of Coverage*** for more information on how to elect post-COBRA extended coverage under California law or enroll in an HMO conversion plan. You can also call Member Services at your HMO.

CONTINUATION OF COVERAGE FOR DOMESTIC PARTNERS

Eligible Domestic Partners of Employees or Retirees and eligible children of Domestic Partners of Employees (children of eligible Retirees are not covered) who lose eligibility under the Plan may temporarily continue Plan coverage through self-payment for a limited period of time. These benefits are **NOT** mandated under federal law. The Board of Trustees may terminate this extension of benefits provision at their sole discretion.

If your Domestic Partnership is registered with the California Secretary of State and you are enrolled in Kaiser, you may apply directly to Kaiser to continue your coverage under the California COBRA Law described above.

You should consult a tax advisor regarding the tax consequences of receiving these benefits, as they may be considered "imputed income" to you under federal law.

Continuation Coverage

The Domestic Partner and children of the Domestic Partner of an Employee who lose eligibility under the Plan may temporarily continue Plan coverage (except dependent life insurance) when eligibility is lost due to any of the following reasons:

- Reporting by your Employer(s) of less than the minimum required hours to the Fund on your behalf for any month;
- Your death;
- Termination of the Domestic Partner relationship with you; or
- Cessation of child's Dependent status under the Plan.

Premiums

A premium for continuation coverage will be charged to the Domestic Partner or Dependent child or both in amounts]established by the Board of Trustees. The premium is payable in monthly installments.

Duration of Continuation Coverage

In the case of your reduction in hours or termination of employment, coverage may be continued on a self-payment basis for up to 18 months from the date of the event that resulted in the loss of eligibility. In all other circumstances, coverage may be continued for up to 36 months from the date of the event that resulted in loss of eligibility.

Continuation coverage will be terminated before the end of the 18-month or 36-month period upon the occurrence of any of the following events:

- The required premium payment for continuation coverage is not paid when due.
- The former Employer of the Employee ceases to provide group health coverage to any of its employees.
- The Domestic Partner or Dependent child becomes covered under any other Group Plan (as a participant or otherwise) or becomes entitled to Medicare coverage.

Election and Notice Procedure

The Domestic Partner, child of a Domestic Partner, or both must elect continuation coverage within 60 days after the later of:

- The date of any of the events described above under "Continuation Coverage"; or
- The date of the notice from the Fund Office notifying the individual of their right to continuation coverage.

INDEMNITY MEDICAL PLAN BENEFITS

HOW THE INDEMNITY MEDICAL PLAN WORKS - YOUR RESPONSIBILITY

The California Service Employees Indemnity Medical Plans 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. It is important to remember that the Indemnity Medical Plan is not designed to cover every health care expense.

The Plan pays charges for eligible expenses, up to the limits and under the conditions established under the rules of the Plan. The decisions about how and when you receive medical care are up to you and your Healthcare Practitioner—not the Plan. The Plan determines how much it will pay; you and your Healthcare Practitioner must decide what medical care is best for you.

Calendar Year Deductible

Individual Deductible

The Calendar Year Deductible is a dollar amount of Covered Expenses that each Participant must pay each calendar year before the Plan starts paying a portion of Covered Expenses. The amount of your Calendar Year Deductible, if any, is shown in your ***Schedule of Medical Benefits***. Note that some Plans do not require any Calendar Year Deductible.

Family Deductible

Each family unit does not need to pay more than the amount shown in your ***Schedule of Medical Benefits*** as charges applied toward the Deductible each calendar year. Once family members have incurred the specified amount of Covered Expenses, the Plan will begin paying all Covered Expenses for family members at the appropriate Coinsurance level.

Coinsurance

Generally, after you meet the Calendar Year Deductible, the Plan begins to pay a percentage of the Covered Expenses. You are responsible for paying the rest of the charges, called coinsurance. The percentage paid for each type of benefit is shown in your ***Schedule of Medical Benefits.*** When you receive services from Anthem Blue Cross Prudent Buyer doctors, hospitals and other healthcare providers, the Plan generally pays a higher percentage of Covered Expenses and Covered Expenses are based on the negotiated contract rates.

When you use the services of healthcare providers who are NOT contracted with Anthem Blue Cross, the Plan generally pays a lower percentage and Covered Expenses are based on the Plan's Allowed Charges. Some expenses may be covered differently or subject to benefit maximums. Refer to your ***Schedule of Medical Benefits*** and the specific descriptions of benefits in this section for more information. You pay any remaining charges not covered by the Plan. Please refer to the section called ***Maximizing Your Medical Benefits*** for more information about using contract providers and the Plan's preauthorization and utilization management programs.

Out-of-Pocket Limit

This Plan has separate **Out-of-Pocket Limits** which limit your annual cost-sharing for covered benefits received from PPO and Non-PPO providers related to medical Plan deductibles, coinsurance, and copays. In addition, there is a separate Out-of-Pocket Limit on In-Network prescription drugs. 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 benefits.

- The Out-of-Pocket Limit is accumulated on a calendar year basis.
- Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.
- The amount of the PPO Provider Out-of-Pocket Limit may be adjusted in accordance with the amount published by the Department of Health and Human Services.
- Out-of-Pocket Limits are NOT interchangeable, meaning you may not use a portion of a PPO Out-of-Pocket Limit to meet a Non-PPO Out-of-Pocket Limit and vice versa, **except** that covered Emergency Services performed in a Non-PPO Emergency Room will apply to meet the PPO Out-of-Pocket Limit.
- 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 this plan's "per person in a family" annual Out-of-Pocket Limit.
- There is a separate medical Out-of-Pocket Limit and outpatient prescription drug Out-of- Pocket Limit. The combined total does not exceed the federal allowances.

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

- Balance-billing charges;
- Penalties for failure to obtain preauthorization;
- Health care this plan doesn't cover;
- Charges in excess of benefit maximums and allowed charges;
- Dental and vision plan expenses, or
- Non-PPO coinsurance except emergency room care in the case of an emergency.

Emergency Services

Emergency Services are covered:

- Without the need for a prior authorization determination, even if the services are provided out-of-network;
- Without regard to whether the health care provider furnishing the Emergency Services is a PPO Provider or a PPO emergency facility, as applicable, with respect to the services;
- Without imposing any administrative requirement or limitation on out-of-network Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO Providers and PPO emergency facilities;

- Without imposing Cost-Sharing Requirements on out-of-network Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO Provider or a PPO emergency facility;
- By calculating the Cost-Sharing Requirement for out-of-network Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and
- By counting any Cost-Sharing payments made by the participant or beneficiary with respect to the Emergency Services toward any in-network deductible or in-network out-of-pocket maximums applied under the Plans (and the in-network deductible and in-network out-of-pocket maximums are applied) in the same manner as if the Cost-Sharing payments were made with respect to Emergency Services furnished by a PPO Provider or a PPO emergency facility.
- In general, you cannot be Balanced Billed for these items or services.

Your cost sharing amount for Emergency Services from Non-PPO Providers will based on the lessor of billed charges from the provider or the Qualified Payment Amount (QPA).

Non-Emergency Items or Services from a Non-PPO Provider at a PPO Facility

With regard to non-emergency items or services that are otherwise covered by the Plans, if the covered non-emergency items or services are performed by a Non-PPO Provider at a PPO facility, the items or services are covered by the Plans:

- With a Cost Sharing Requirement that is no greater than the Cost-Sharing Requirement that would apply if the items or services had been furnished by a PPO Provider,
- By calculating the Cost-Sharing requirements as if the total amount that would have been charged for the items and services by such PPO Provider were equal to the Recognized Amount for the items and services,
- By counting any Cost-Sharing payments made by the participant or beneficiary toward any in-network deductible and in-network out-of-pocket maximums applied under the Plans (and the in-network deductible and out-of-pocket maximums must be applied) in the same manner as if such Cost-Sharing payments were made with respect to items and services furnished by a PPO Provider,
- Non-emergency items or services performed by a Non-PPO Provider at a PPO facility will be covered based your out-of-network coverage if:
- At least 72 hours before the day of the appointment (or three (3) hours in advance of services rendered in the case of a same-day appointment), the participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-PPO Provider with respect to the Plans, of the estimated charges for your treatment and any advance limitations that the Plans may put on your treatment, of the names of any PPO Providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO Providers listed; and
- The participant or dependent gives informed consent to continued treatment by the Non-PPO Provider, acknowledging that the participant or beneficiary understands that

continued treatment by the Non-PPO Provider may result in greater cost to the participant or beneficiary.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the Non-PPO Provider satisfied the notice and consent criteria, and therefore these services will be covered:

- With a Cost-Sharing Requirement that is no greater than the Cost-Sharing Requirement that would apply if the items or services had been furnished by a PPO Provider,
- With Cost-Sharing Requirements calculated as if the total amount charged for the items and services were equal to the Recognized Amount for the items and services, and
- With Cost-Sharing counted toward any in-network deductible and in-network out of pocket maximums, as if such Cost-Sharing payments were with respect to items and services furnished by a PPO Provider.

Your Cost Sharing amount for Non-Emergency Services at PPO Facilities by Non-PPO Providers will based on the lessor of billed charges from the provider or the QPA.

Air Ambulance Services

If you receive Air Ambulance services that are otherwise covered by the Plans from a Non-PPO Provider, those services will be covered by the Plans as follows:

- The Air Ambulance services received from a Non-PPO Provider will be covered with a Cost-Sharing Requirement that is no greater than the Cost-Sharing Requirement that would apply if the services had been furnished by a PPO Provider.
- The Cost-Sharing Amount will be calculated as if the total amount that would have been charged for the services by a PPO Provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.
- Any Cost-Sharing payments you make with respect to covered Air Ambulance services will count toward your in-network deductible and in-network out-of-pocket maximum in the same manner as those received from a PPO Provider.
- In general, you cannot be Balance Billed for these items or services.

Payments to Non-PPO Providers and Facilities

The Plan will make an initial payment or notice of denial of payment for Emergency Services, Non-Emergency Services at PPO Facilities by Non-PPO Providers, and Air Ambulance Services within 30 calendar days of receiving a clean claim from the Non-PPO Provider. The 30-day calendar period begins on the date the Plan receives the information necessary to decide a claim for payment for the services.

If a claim is subject to the No Surprises Act, the participant cannot be required to pay more than the Cost-Sharing Amount under the Plan, and the provider or facility is

prohibited from billing the participant or dependent in excess of the required Cost-Sharing Amount (also known as “Balance Billing”).

The Plans will pay a total plan payment directly to the Non-PPO Provider that is equal to the amount by which the Out-of-Network Rate for the services exceeds the Cost-Sharing Amount for the services, less any initial payment amount.

Continuity of Coverage

If you are a Continuing Care Patient, and the contract with your PPO provider or facility terminates, or your benefits under a group health plan are terminated because of a change in terms of the providers’ and/or facilities’ participation in the plan:

1. You will be notified in a timely manner of the contract termination and of your right to elect continued transitional care from the provider or facility; and
2. You will be allowed up to ninety (90) days of continued coverage at the Network Cost-Sharing Amount to allow for a transition of care to a Network provider.

Incorrect PPO Provider Information

A list of PPO Providers is available to you without charge by visiting the website or by calling the phone number on your ID card. The network consists of providers, including hospitals, of varied specialties as well as general practice, who are contracted with the Plans or an organization contracting on its behalf.

If you obtain and rely upon incorrect information provided by the Plans about whether a provider is a PPO Provider from the Plans or its administrators, the Plans will apply the PPO Cost-Sharing Amount to your claim, even if the provider was a Non-PPO Provider.

Patient Protection Rights of the Affordable Care Act

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

You also do not need prior authorization from the Plan or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact the medical network at their website listed on the Quick Reference Chart.

Nondiscrimination in Health Care

In accordance with the Affordable Care Act, to the extent an item or service is a covered benefit under the Plan, and consistent with reasonable medical management techniques with respect to the frequency, method, treatment or setting for an item or service, the Plan will not discriminate with respect to participation under the Plan or coverage against any health care provider who is acting within the scope of that provider’s license or certification under applicable State law. In this context, discrimination means treating a

provider differently based solely on the type of the provider's license or certification. The Plan is not required to contract with any health care provider willing to abide by the terms and conditions for participation established by the Plan. The Plan is permitted to establish varying reimbursement rates based on quality or performance measures.

Allowed Charges

The Plan pays charges from Non-PPO providers only to the extent that they are "Allowed Charges." You will find a complete definition of Allowed Charges in the ***Glossary of Defined Terms***.

What is Medically Necessary?

The Plan pays benefits only for services and supplies that are Medically Necessary as determined by the Plan. You will find the Plan's definition of the term "Medically Necessary" in the ***Glossary of Defined Terms***.

Maximizing Your Medical Benefits

The Plan has two cost management programs designed to help manage certain health care expenses, a preauthorization and utilization management (UM) program.

Preferred Provider Organization (PPO) Network

The Board of Trustees has contracted with Anthem Blue Cross Prudent Buyer to provide a network of doctors, hospitals and other healthcare providers. Health Care Practitioners and hospitals participating in the Anthem Blue Cross Prudent Buyer Network have agreed to negotiated fees that are less than their normal billed charges and to meet Anthem Blue Cross's standards. A directory of Preferred Providers may be requested, free of charge, from the Fund Office or you may visit the Anthem Blue Cross website at www.anthem.com/ca.

It is your decision whether to use an Anthem Blue Cross provider. You always have the final say about the Health Care Practitioners and hospitals you and your family use. However, for most covered services, your coinsurance obligation will be lower if you use a contracted provider.

Preauthorization and Utilization Management Program

The Preauthorization requirements described in this section do not apply to Emergency Services, if you are entitled to Medicare or if this Plan is the secondary payer. You also do not need to pre-certify a hospital admission for childbirth if the admission is for less than 48-hours for a vaginal delivery or 96-hours following a cesarean section delivery.

Preauthorization of Hospitalizations

The Board of Trustees has also contracted with Anthem Blue Cross to provide preauthorization and utilization management services. These services help ensure that you receive quality care in a way that uses our valuable health care resources as wisely as possible. To make it work, we need you to become involved in the decisions regarding your care.

Whenever your doctor suggests a **hospital admission** Anthem Blue Cross must be notified. Your Anthem Blue Cross PPO doctor will generally do this for you. **However, if**

you use a Non-PPO doctor it is your responsibility to ensure that Anthem Blue Cross is notified.

Prior to all elective Hospital Admissions, call Anthem Blue Cross at (800) 274-7767

In the case of an Emergency Services admission, Anthem Blue Cross must be notified within 24 hours after the admission.

Penalty for Failure to Pre-Authorize

It is very important to call for preauthorization if your Healthcare Practitioner recommends hospitalization. **Failure to do so will result in a $200 penalty (a reduction of your benefits).**

The Anthem Blue Cross professional medical review staff can provide you with treatment alternatives, preauthorization, and referrals when needed. When you or your Healthcare Practitioner calls Anthem Blue Cross before a hospital admission, the representative will evaluate whether a hospital admission is medically necessary along with a determination about the proposed length of stay.

Concurrent Utilization Management

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

Large Case Management

Case Management defined: Case management is a voluntary process, administered by Anthem Blue Cross. Its medical professionals work with the patient, family, caregivers, health care providers, and the Fund Office to coordinate a timely and cost-effective treatment program. Case management services are particularly helpful when the patient needs complex, costly, and/or high-technology services, and when assistance is needed to guide patients through a maze of potential health care providers.

Working with the Case Manager: Any Plan Participant, Physician, or other Health Care Provider can request Case Management services by calling Anthem Blue Cross at (800) 274-7767. However, in most cases, Anthem Blue Cross will be actively searching for those cases where the patient could benefit from Case Management services, and it will initiate Case Management services automatically.

The Case Manager at Anthem Blue Cross will work directly with your Healthcare Practitioner, hospital, and/or other health care facility to review proposed treatment plans and to assist in coordinating services and obtaining discounts from health care providers as needed. From time to time, the Case Manager may confer with your Healthcare Practitioner or other health care providers, and may contact you or your family to assist in making plans for continued health care services, and to assist you in obtaining information to facilitate those services.

You, your family, or your Healthcare Practitioner may call the Case Manager at Anthem Blue Cross at any time by calling Anthem Blue Cross at **(800) 274-7767.**

Out-of-Area Services

Overview

We have a variety of relationships with other Blue Cross and/or Blue Shield Licensees. Generally, these relationships are called "Inter-Plan Arrangements." These Inter-Plan Arrangements work based on rules and procedures issued by the Blue Cross Blue Shield Association ("Association"). Whenever you access healthcare services outside the geographic area we serve (the "Anthem Service Area"), the claim for those services may be processed through one of these Inter-Plan Arrangements. The Inter-Plan Arrangements are described below.

When you receive care outside of the Anthem Service Area, you will receive it from one of two kinds of Providers. Most Providers ("participating providers") contract with the local Blue Cross and/or Blue Shield Plan in that geographic area ("Host Blue"). Some Providers ("nonparticipating providers") don't contract with the Host Blue. We explain below how we pay both kinds of Providers.

Inter-Plan Arrangements Eligibility – Claim Types

Most claim types are eligible to be processed through Inter-Plan Arrangements, as described above. Examples of claims that are not included are prescription drugs that you obtain from a pharmacy and most dental or vision benefits. The Emergency Services payment rules described above continue to apply as required under law.

A. BlueCard® Program

Under the BlueCard® Program, when you receive Covered Services within the geographic area served by a Host Blue, Anthem will still fulfill its contractual obligations. The Host Blue is responsible for: (a) contracting with its Providers; and (b) handling its interactions with those Providers.

When you receive covered services outside the Anthem Service Area and the claim is processed through the BlueCard Program, the amount you pay is calculated based on the lower of:

- The billed charges for covered services; or
- The negotiated price that the Host Blue makes available to Anthem.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Blue pays to the Provider. Sometimes, it is an estimated price that takes into account special arrangements with that Provider. Sometimes, such an arrangement may be an average price, based on a discount that results in expected average savings for services provided by similar types of Providers. Estimated and average pricing arrangements may also involve types of settlements, incentive payments and/or other credits or charges.

Estimated pricing and average pricing also take into account adjustments to correct for over- or underestimation of past pricing of claims, as noted above. However, such adjustments will not affect the price we used for your claim because they will not be applied after a claim has already been paid.

B. Negotiated (non–BlueCard Program) Arrangements

With respect to one or more Host Blues, instead of using the BlueCard Program, Anthem may process your claims for covered services through negotiated arrangements for national accounts.

The amount you pay for covered services under this arrangement will be calculated based on the lower of either billed charges for covered services or the negotiated price (refer to the description of negotiated price under Section A, BlueCard Program) made available to Anthem by the Host Blue.

C. Special Cases: Value-Based Programs

BlueCard® Program

If you receive Covered Services under a value-based program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or care coordinator fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem through average pricing or fee schedule adjustments.

If Anthem has entered into a negotiated arrangement with a Host Blue to provide value-based programs to the Fund on your behalf, Anthem will follow the same procedures for value-based programs administration and care coordinator fees as noted above for the BlueCard Program.

D. Nonparticipating Providers Outside Anthem Service Area

1. **Allowed Amounts and Member Liability Calculation**

   When Covered Services are provided outside of Anthem's Service Area by non-participating providers, the Fund may determine benefits and make payment based on pricing from either the Host Blue or the pricing arrangements required by applicable state or federal law. In these situations, the amount you pay for such services as deductible, copayment or coinsurance will be based on that allowed amount. Also, you may be responsible for the difference between the amount that the non-participating provider bills and the payment the Fund will make for the Covered Services as set forth in this paragraph. Federal law, as applicable, will govern payments for out-of-network Emergency Services.

2. **Exceptions**

   In certain situations, the Fund may use other pricing methods, such as the pricing it would use if the healthcare services had been obtained within the Anthem Service Area, or a special negotiated price to determine the amount the Fund will pay for services provided by nonparticipating providers. In these situations, you may be liable for the difference between the amount that the nonparticipating provider bills and the payment the Fund makes for the Covered Services as set forth in this paragraph.

E. BlueCard Worldwide® Program

If you plan to travel outside the United States, call customer service to find out your BlueCard Worldwide benefits. Benefits for services received outside of the United States may be different from services received in the United States. The plan only covers Emergency, including ambulance, outside of the United States. Remember to take an up to date health ID card with you.

When you are traveling abroad and need medical care, you can call the BlueCard Worldwide Service Center any time. They are available 24 hours a day, seven days a week. The toll free number is 800-810-2583. Or you can call them collect at 804-673-1177.

How claims are paid with BlueCard Worldwide

In most cases, when you arrange inpatient hospital care with BlueCard Worldwide, claims will be filed for you. The only amounts that you may need to pay up front are any copayment, coinsurance or deductible amounts that may apply.

You will typically need to pay for the following services up front:

- Doctors services;
- Inpatient hospital care not arranged through BlueCard Worldwide; and
- Outpatient services.

You will need to file a claim form for any payments made up front.

When you need BlueCard Worldwide claim forms you can get international claims forms in the following ways:

- Call the BlueCard Worldwide Service Center at the numbers above; or
- Online at www.bluecardworldwide.com.

You will find the address for mailing the claim on the form.

INDEMNITY MEDICAL PLAN COVERED EXPENSES

The Indemnity Medical Plan covers the charges listed in this section to the extent that they are:

- Medically Necessary;
- Due to illness or injury (except as specifically provided for under ***Preventive Care Benefits);***
- Performed or ordered by a provider acting within the scope of his or her license;
- Expenses are incurred while you and your eligible Dependents are eligible under the Plan; and
- Within the maximum limits specified by the Plan.

  If you incur charges for medical services or supplies that are in excess of what the Plan considers to be the Allowed Charge (see ***Glossary of Defined Terms***), you will be responsible for payment of the excess amount.

Hospital Claims

Anthem Blue Cross PPO hospitals will automatically file claims directly with Anthem. Most other Non-PPO hospitals will also file claims directly with the Fund Office. However, it is your responsibility to ensure that the claim is filed (see below for instructions). If you do not receive an Explanation of Benefits from the Plan within 30 days of your discharge from the hospital, you should call the Administrative Office and ask if the claim has been filed.

Claims for Medical Services

Anthem Blue Cross PPO providers will automatically file claims directly with Anthem. Most other providers will also file claims with the Fund Office.

To file a claim for medical services that have already been received, the following information must be provided in order for your request for benefits to be a claim and for the Administrative Office to be able to process your claim:

- Participant name
- Patient name
- Patient Date of Birth
- Member ID number or Social Security Number of Participant
- Date of Service
- CPT-4 and diagnosis code

  The claim should be filed with the Fund Office at the following address:

  California Service Employees Health and Welfare Trust Fund
  c/o Northwest Administrators
  2323 Eastlake Ave Easth
  Seattle, WA 98102

Special Provision for Mastectomy Patients

Under the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive surgery. In the case of a Participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending Healthcare Practitioner and the patient, for:

- Reconstruction of the breast on which the mastectomy was performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prosthesis and treatment of physical complication at all stages of the mastectomy, including lymphedemas.

These services are subject to all Plan provisions.

When Claims Must Be Filed

Claims for medical and hospital services (as well as any extension of benefits) that have been received should be filed within 90 days after you receive the services. If you have not received either an ***Explanation of Benefits*** from the Administrative Office or a bill for the services or supply from the provider, you should call the provider to ensure that they have the correct billing information. All claims must be submitted to the Administrative Office within one year after the date on which services were received.

Schedule of Medical Benefits

A schedule of the Plan's Medical Benefits appears on the following pages in a chart format. Each of the Plan's Medical Benefits is described in the first column. Explanations and limitations that apply to each of the benefits are shown in the second column. **The specific Plan (including medical and prescription benefits) provided to you by the Fund are determined by the terms of the *Collective Bargaining Agreement* between your Signatory Employer and your Service Employees International Union – CTW.**

In the Schedule of Medical Benefits Deductibles, Out-of-Pocket Limits, Hospital services (Inpatient) and Physician services are listed in the first few rows because these categories of benefits apply to most (but not all) health care services covered by the Plan. These rows are followed by descriptions, appearing in **alphabetical** order, of the other covered medical benefits along with any limitations and exclusions to those covered benefits.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

All medical plan claims must be submitted to the Plan within **ONE YEAR** after the date on which the services were received except for legal incapacity. No Plan benefits will be paid for any claim submitted after this period.

MEDICAL BENEFITS SUMMARY (FOR PLANS 2, 3 AND 4)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Please check your employer's Collective Bargaining Agreement to confirm your medical plan option.

THE SCHEDULE OF BENEFITS FOR PLANS 5, 5B, 6 AND 7 BEGINS ON PAGE Error! Bookmark not defined.

Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Deductible The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits. Deductibles are applied in the order in which claims are processed by the Plan.	• Note that the PPO and Non-PPO deductibles are interchangeable, meaning that you may use a portion of a PPO deductible to meet a Non-PPO deductible and vice versa. • **All benefits in this Schedule of Benefits are subject to the deductible except where noted.**	None		None		$100 individual $300 family Does not apply to Retiree and Spouse who are eligible for Medicare	
Out-of-Pocket Limit (OOP) The OOP Limit is the most you pay the calendar year before your plan starts to pay 100% for covered benefits. The Out-of-Pocket Limit accumulates on a calendar year basis. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.	The medical Out-of-Pocket Limit does not include or accumulate copays on prescription drugs (a separate Out-of-Pocket Limit applies to In-Network prescription drugs), balance-billing charges, penalties for failure to obtain preauthorization, health care this plan doesn't cover, charges in excess of benefit maximums and allowed charges, dental and vision plan expenses. The PPO Out-of-Pocket Limit also does not include-Non-PPO coinsurance except emergency room care in the case of an emergency. The Non-PPO Out-of-Pocket Limit also does not include PPO coinsurance or Emergency Services provided in an emergency room.	**Medical:** $4,000 per person; $8,000 per family **Prescription drugs:** $2,600 per person $5,200 per family	$6,000 per person	**Medical:** $4,000 per person; $8,000 per family **Prescription drugs:** $2,600 per person $5,200 per family	$6,000 per person	**Medical:** $4,000 per person, $8,000 per family. **Prescription drugs:** $2,600 per person, $5,200 per family	$6,000 per person

MEDICAL BENEFITS SUMMARY (FOR PLANS 2, 3 AND 4)

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THE SCHEDULE OF BENEFITS FOR PLANS 5, 5B, 6 AND 7 BEGINS ON PAGE Error! Bookmark not defined.

Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units within the hospital (e.g., intensive care unit). • Lab/x-ray/diagnostic services. • Medically Necessary ancillary services (e.g., prescriptions, supplies). • Newborn care.	**Elective Hospitalization requires preauthorization** to avoid a $200 penalty. Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms. The professional fees are usually billed separately from the facility fee. Newborn eligible Dependents will be covered from the date of birth. However, it is very important that you request a new Enrollment Form within 60 days of the birth of your baby in order to make sure the child is properly enrolled.	90%	85%	95%	80% for room and board and 100% for miscellaneous services	100% after Deductible	100% after Deductible
Physician Services The Plan covers services provided by Health Care Practitioners for either inpatient or outpatient consultations. Chiropractors, podiatrists, physical therapists, speech therapists and occupational therapists, and other Allied Health Care Practitioners are also covered.	• Under this Plan, there is no requirement to select a primary care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider. • No more than one visit is payable for any one provider on the same day.	90%	85%	95%	85%	**Outpatient:** 90% **Inpatient:** 100% after Deductible	**Outpatient**: 80% **Inpatient:** 100% after Deductible
Accident Expense Benefit		Not Applicable		100% of the first $500 for treatment within 90 days of an accident		Not Applicable	

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Allergy Services The Plan covers allergy testing, serum and injections.		90%	85%	95%	85%	90%	80%
Ambulance Services The Plan covers: • Emergency transportation by local professional ambulance when the condition of the patient requires paramedic support. • Air ambulance only when the medical condition of the patient requires such transport to safely transport the patient to the nearest facility that can treat the injury or illness.	• You will not be balance billed for covered Non-PPO air ambulance services.	90%	**Ground Ambulance:** 85% **Air Ambulance:** 90%	95%	**Ground Ambulance:** 85% **Air Ambulance:** 95%	90%	**Ground Ambulance:** 80% **Air Ambulance:** 90%
Chiropractic Services	Chiropractors, Physical Therapists, Speech Therapists, Occupational Therapists and Respiratory Therapists 50 visits per accident or illness for all providers combined (increased to 60 visits in certain situations). Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.	90%	85%	95%	85%	90%	80%

MEDICAL BENEFITS SUMMARY (FOR PLANS 2, 3 AND 4)

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Dental Services • Accidental injury to teeth/jaw	• Treatment of an accidental injury to the jaw or teeth is covered when treatment occurs within six months after the date of an accident (applied without respect to when the individual is enrolled in the Plan). • Replacement of teeth is not covered under the medical plan.	90%	85%	100% of first $500 within 90 days of an accident (deductible waived), then 95% after deductible	100% of first $500 within 90 days of an accident (deductible waived), then 85% after deductible	90%	80%
Diabetes Training and Education	• Upon referral by the patient's physician, an approved Diabetes Self-Management Program is covered. The program must be directed by a Physician who specializes in the treatment of diabetes and is provided by licensed providers acting within the scope of their license.	100%	85%	100%	85%	100% after Deductible	50%
Durable Medical Equipment (DME) Covered Expenses include rental (or purchase, if cost effective) of medically necessary durable medical equipment (DME), such as: • Hospital bed; • Wheelchair; or • Oxygen and other durable medical equipment used solely by the eligible individual for the treatment of illness or injury.	Coverage is provided for a standard manual or standard electric breast pump, plus the supplies needed to operate the breast pump. A hospital grade breast pump is payable if the Plan determines it to be medically necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child.	**Breast Pump:** 100% **All other:** 90%	85%	100%	100%	**Breast Pump:**100%, Deductible waived **All other**: 90%	80%

MEDICAL BENEFITS SUMMARY (FOR PLANS 2, 3 AND 4)

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Emergency Services Emergency services are covered: • Without the need for any prior authorization determination, even if the services are provided on a Non-PPO basis; • Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility; • Without imposing any administrative requirements or limitations on Non-PPO Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities.	• Services received at a hospital Emergency Room for treatment of an Emergency Medical Condition (as defined by the Plan) do not require prior certification. • If you receive Emergency Services in a PPO hospital from a non-PPO Physician, the Plan will pay the Physician services at the PPO level of benefits based on the lessor of billed charges from the provider or the Qualifying Payment Amount. • Your cost-sharing payments for Emergency Services (PPO or Non-PPO) will count toward any PPO out-of-pocket maximum.	90%	**Emergency Room:** 90% **Urgent Care:** 85%	**Emergency Room:** 100% **Urgent care:** 95%	**Emergency Room:** 100% **Urgent care:** 85%	**Emergency Room:** 100% after Deductible **Urgent care:** 90%	**Emergency Room:** 100% after Deductible **Urgent care:** 80%

MEDICAL BENEFITS SUMMARY (FOR PLANS 2, 3 AND 4)

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Family Planning, Reproductive, Fertility Services • Coverage is provided for FDA-approved female contraceptives such as oral birth control pills/patch, emergency contraception, injectables intrauterine device (IUD) and removal of IUD, cervical cap, contraceptive ring, diaphragm, implantable birth control device/service. • This benefit includes elective abortion for either the Employee or the Employee's Spouse but not for a Dependent child.	• No coverage for reversal of sterilization procedures. • Fertility and infertility services are payable for the diagnosis and treatment of medical conditions that result in infertility but not for expenses related to services that induce pregnancy including, but not limited to, surgical impregnation procedures like in-vitro fertilization. • Coverage is provided without cost sharing for items and services integral to the furnishing of contraceptive services, such as anesthesia for a tubal ligation procedure or pregnancy tests needed before the provision of certain forms of contraception, such as an intrauterine device (IUD) regardless of whether the items and services are billed separately. • An exceptions process is available if an individual's health care provider recommends an item or service not covered under the plan's contraceptive coverage policies.	**Female contraceptives and female sterilization procedures:** 100% **All other:** 90%	85%	**Female contraceptives and female sterilization procedures:** 100% **All other:** 95%	85%	**Female contraceptives and female sterilization procedures:** 100%, Deductible waived **All other:** 90%	80%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Home Health Care Covered Expenses include intermittent nursing care provided by a registered nurse or other licensed health care provider. The patient must be under the continuous care of a physician. Someone related to the patient by blood or marriage or otherwise residing in the patient's home is not considered to be a home health provider unless that person is a licensed health care provider.	• Home health care services require preauthorization to avoid a $200 penalty • Maximum benefit of 100 visits per calendar year. Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice. • Four hours of home health care aide services which consist primarily of medical or therapeutic caring for the patient, and are not primarily custodial in nature, will be considered one visit. • Physical, occupational or speech therapy ordered by the patient's primary physician and provided by the Home Healthcare Agency are included in this benefit. • Medical supplies, infusion therapy and laboratory services provided by the Home Healthcare Agency are covered to the extent that these items would have been covered had the patient been hospitalized.	85%	85%	100%	100%	100% after Deductible	100% after Deductible

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Hospice • Hospice services include inpatient hospice care and outpatient home hospice when Medically Necessary.	• Covered only when ordered by a Physician. • Inpatient hospice limited to a lifetime maximum of 60 days. Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice. • Bereavement counseling will be covered as an outpatient Mental Health benefit.	85%	85%	100%	100%	100% after Deductible	100% after Deductible
Laboratory Services (Outpatient) • Technical and professional fees.	• Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical • Some laboratory services are payable under the Wellness benefits in this Schedule. • A PSA test is covered once a year or as Medically Necessary.	90%	85%	No charge	No charge for first $1,000, then 80%	90%	80%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Maternity Services • Hospital and Birthing Center charges and Professional fees for Medically Necessary maternity services. • Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable as preventive care services. • Comprehensive lactation support and counseling (including breastfeeding classes) when provided by a PPO provider. • Under federal law, plans may not require preauthorization or restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The Plan may pay for a shorter stay if the attending Physician, after consultation with the mother, discharges the mother or newborn earlier.	• Pregnancy-related care is covered for a female employee or Spouse only. No coverage is provided for maternity expenses of Dependent children except for certain preventive care expenses required under ACA and Emergency Services under the No Surprises Act. • Prenatal and postnatal office visits obtained from a PPO provider are payable at no cost. Normal plan cost-sharing applies to all other maternity related services including ultrasounds and delivery fees. • **.Elective induced abortion** is covered only for the Employee or Spouse.	**Breastfeeding support and counseling** 100%, Deductible waived **Prenatal office visit and ACA required preventive screenings:** No charge **All other:** 90%	85%	**Breastfeeding support and counseling** 100%, Deductible waived **Prenatal office visit and ACA required preventive screenings:** No charge **All other:** 95%	**Inpatient** 80% for room and board and 100% for miscellaneous services **All other:** 85%	**Breastfeeding support and counseling** 100%, Deductible waived **Prenatal office visit and ACA required preventive screenings:** No charge, Deductible waived **Inpatient:** No charge after Deductible **All other:** 90%	**Breastfeeding support and counseling** 50% **Prenatal office visit and ACA required preventive screenings:** 50% **Inpatient:** No charge after Deductible **All other:** 80%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Medical Supply and Prosthetics Covered Expenses include: • Casts, splints, braces, crutches, and surgical dressings. • Custom made orthotics that are Medically Necessary to treat a symptomatic disorder of the foot. • Blood, blood plasma, and its administration. • Oxygen and its administration. • Artificial limbs and eyes. • Breast prosthesis following a mastectomy and subsequent prosthesis when ordered by a physician. • Initial purchase of eyeglasses or contact lenses as a result of cataract surgery. • Hearing Aids, including fitting • Prosthetic devices to restore a method of speaking incident to a laryngectomy (removal of the larynx or voice box) but not including electronic voice producing machines.	• Replacement of batteries or repairs of hearing aids are not covered.	90%	85%	95%	85%	90%	80%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Mental Health and Substance Abuse Treatment • **Inpatient hospital admission** and residential treatment programs. • **Outpatient visits** including partial day care/partial day treatment and intensive outpatient program (IOP)	• Elective inpatient admission to a hospital or residential treatment program requires preauthorization to avoid a $200 penalty.	90%	85%	95%	**Inpatient** 80% for room and board and 100% for miscellaneous services **Outpatient** 85%	**Inpatient**: 100% (after any applicable deductible) **Office visits:** 90% **Other Outpatient Services:** 100% (any deductible will be waived)	**Inpatient:** 100% (after any applicable deductible) **Office visits:** 80% **Other Outpatient Services:** 100% (any deductible will be waived)
Outpatient Hospital and Free Standing Surgical facility • Services provided by a hospital on an outpatient basis, including surgery for which you are not admitted to the hospital and you are discharged in 23 hours or less; • Diagnostic imaging, including MRIs and CT Scans; • Endoscopic procedures • Therapeutic radiation treatment • Professional fees are usually billed separately from the facility fee.		90%	85%	95%	85%	100%	100%
Radiation Therapy and Chemotherapy		90%	85%	100%	100%	90%	80%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Radiology (X-Ray), and Imaging Services Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician. • Some radiology procedures are covered under the Preventive care benefits described in this Schedule.	90%	85%	No charge	No charge for first $1,000, then 80%	90%	80%
Rehabilitation Services (Physical, Occupational & Speech Therapy) • Short term **active**, **progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified Health Care Practitioner as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active**, **progressive** Rehab services **that cannot be provided in an outpatient or home setting.**	• Inpatient Rehabilitation admission requires preauthorization to avoid a $200 penalty. • Chiropractors, Physical Therapists, Speech Therapists, Occupational Therapists and Respiratory Therapists limited to 50 visits per accident or illness for all providers combined (increased to 60 visits in certain situations). Visit limits will not apply to diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice.	90%	85%	95%	85%	90%	80%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility. • The professional fees are usually billed separately.	• Admission to a Skilled nursing facility requires preauthorization to avoid a $200 penalty. • Skilled Nursing Facility confinement or Subacute care facility confinement is payable up to 100 days per calendar year. Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.	85%	85%	100%	100%	100%, Deductible waived	100%, Deductible waived
Smoking/Tobacco Cessation Benefits •This benefit can be used to help with nicotine addiction (to stop smoking or stop chewing tobacco).	Coverage includes screening for tobacco use; and, for those who use tobacco products, at least two tobacco cessation attempts per year. Cessation attempt includes coverage for: • Four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and • All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.	100%	85%	100%	85%	100%, Deductible waived	80%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Transplants (Organ and Tissue) •Coverage is provided only for eligible services directly related to Medically Necessary and non-experimental transplants of human organs or tissue.	• **Transplant services require preauthorization to avoid a $200 penalty.** • For plan participants who serve as a donor, Donor Expenses, including testing, related to any organ/tissue transplant procedure, unless the organ recipient is covered under this Plan and such expenses are not eligible for coverage under any other benefit plan, whether insured or not. All such costs must be approved in advance by Anthem.	90%	85%	95%	**Inpatient:** 80% for room and board and 100% for miscellaneous services **Outpatient:** 85%	**Inpatient:** 100% after Deductible **Outpatient:** 90%	**Inpatient:** 100% after Deductible **Outpatient:** 80%
Weight Management and Nutritional Counseling As a **preventive counseling benefit** in compliance with ACA, the Plan covers **intensive behavioral counseling interventions.**	•**Adults:** For adults with a body mass index of 30 or higher, up to a combined limit of 26 individual or group visits per year by a PPO provider. •**Children:** For children age 6 years and older with obesity, the Plan covers intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's Provider. •Diet drugs, appetite suppressants or other weight loss drugs are **not** covered.	100%	85%	100%	85%	100%, Deductible waived	50%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Wellness (Preventive) Children	The Plan covers: •Well baby and well child visits through age 21; •Age appropriate screenings and behavioral assessments; •Childhood immunizations (including COVID-19); •For obese children age 6 and older, **intensive behavioral counseling** interventions as described in row titled "weight management". •Gonorrhea preventive medication for the eyes provided for the newborn during hospital confinement for birth; •Fluoride varnish applied to the primary teeth of children to age 5; •Counseling for children ages 10-24 years who have fair skin about reducing risk for skin cancer; •Tobacco education or brief counseling to prevent initiation of tobacco use in school aged children. Where the information in this document conflicts with ACA regulations affecting preventive care coverage, this Plan will comply with the requirements on the date required. Preventive services are payable without regard to gender assigned at birth, or current gender status. The frequency for ACA preventive service recommendation is specified in these websites: https://www.healthcare.gov/what-are-my-preventive-care-benefits/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index. The frequency of preventive visits for children is payable in accordance with the "Recommendations for Preventive Pediatric Health Care" from Bright Futures/American Academy of Pediatrics, updated periodically, (website for the schedule is: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf). If these websites do not specify a frequency for which the preventive service should be performed, the Plan will pay for the preventive service when performed no more frequently than once a calendar year. Occupational or Travel immunizations, (e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.	100%	85%	100%	85%	100%, Deductible waived	50%

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		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Wellness (Preventive) Men The Plan covers: • Immunizations as required under ACA (including COVID-19); • Screenings for alcohol misuse, chlamydia, diabetes, depression, obesity, HIV, blood pressure, cholesterol, Syphilis, hepatitis C, abdominal aortic aneurysm, lung cancer and Hepatitis B. • Tobacco use screening and 2 annual cessation interventions; • For overweight men, intensive behavioral counseling as outlined in row titled "weight loss". • Colorectal screening (including fecal occult blood testing, sigmoidoscopy or colonoscopy) for ages 45 and over. Where the information in this document conflicts with newly released Affordable Care Act regulations preventive care coverage, this Plan will comply with the new requirements on the date required Preventive services are payable without regard to gender assigned at birth, or current gender status. The frequency for ACA preventive service recommendation is specified in these websites: *https://www.healthcare.gov/what-are-my-preventive-care-benefits/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index*. If these websites do not specify a frequency for which the preventive service should be performed, such as is the case for a preventive office visit or cholesterol screening, the Plan will pay for the preventive service when performed no more frequently than once a calendar year. Occupational immunizations and travel immunizations (e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.		100%	85%	100%	85%	100%, Deductible waived	50%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 2		PLAN 3		Plan 4	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Wellness (Preventive) Woman – The Plan covers: • Well woman office visit; • Immunizations as required under ACA (including COVID-19); • Screenings for alcohol misuse, chlamydia, domestic violence, diabetes, lung cancer, depression, obesity, gonorrhea, HIV, blood pressure, cholesterol, HPV, osteoporosis, cervical cancer, Syphilis, hepatitis C and Hepatitis B. • For pregnant women, the following additional screenings: bacteriuria, gestational diabetes, Rh Incompatibility. • Tobacco use screening, 2 annual cessation interventions; • Counseling for domestic violence. • Sexually transmitted infection counseling if at increased risk. • For overweight women, intensive behavioral counseling as described in row titled "weight loss". • BCRA counseling and BCRA 1 or 2 genetic tests; • Breast cancer chemoprevention; • Mammogram for women ages 40 and older; • Contraceptive education, counseling and sterilization procedures. (Contraceptives are payable under the Family Planning Benefit); • Colorectal screening (including fecal occult blood testing, sigmoidoscopy or colonoscopy) for ages 45 and over. Where the information in this document conflicts with ACA regulations affecting preventive care coverage, this Plan will comply with the requirements on the date required. Preventive services are payable without regard to gender assigned at birth, or current gender status. The frequency for ACA preventive service recommendation is specified in these websites: *https://www.healthcare.gov/what-are-my-preventive-care-benefits/*, *http://www.hrsa.gov/womensguidelines/*, and *http://www.cdc.gov/vaccines/schedules/hcp/index.html*, and *http://www.uspreventiveservicestaskforce.org/BrowseRec/Index*. If these websites do not specify a frequency for which the preventive service should be performed, the Plan will pay for the preventive service when performed no more frequently than once a calendar year. Occupational immunizations and travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.		100%	85%	100%	85%	100%, Deductible waived	50%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Please check your employer's Collective Bargaining Agreement to confirm your medical plan option.

THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Deductible The annual deductible is the amount of money you must pay each calendar year before the Plan begins to pay benefits. Deductibles are applied in the order in which claims are processed by the Plan.	• Note that the PPO and Non-PPO deductibles are interchangeable, meaning that you may use a portion of a PPO deductible to meet a Non-PPO deductible and vice versa. • **All benefits in this Schedule of Benefits are subject to the deductible except where noted.**	$500 per individual $1,000 per family Deductible does not apply to a Retiree and Spouse eligible for Medicare		$250 per individual $500 per family Deductible does not apply to a Retiree and Spouse eligible for Medicare		$100 per individual $300 per family Deductible does not apply to a Retiree and Spouse eligible for Medicare		$200 per individual $600 per family Deductible does not apply to a Retiree and Spouse eligible for Medicare	
Out-of-Pocket Limit (OOP) The OOP Limit is the most you pay the calendar year before your plan starts to pay 100% for PPO covered benefits. The Out-of-Pocket Limit accumulates on a calendar year basis. Covered expenses are applied to the Out-of-Pocket Limit in the order in which eligible claims are processed by the Plan.	The OOP Limit does not include or accumulate copays on prescription drugs (a separate OOP Limit applies to In-Network prescription drugs), balance-billing charges, penalties for failure to obtain preauthorization, health care this plan doesn't cover, charges in excess of benefit maximums and allowed charges, dental and vision plan expenses. The PPO Out-of-Pocket Limit also does not include Non-PPO coinsurance except emergency room care in the case of an emergency. The Non-PPO Out-of-Pocket Limit also does not include PPO coinsurance or Emergency Services provided in an emergency room.	**Medical:** $4,000 per person; $8,000 per family **Prescription drugs:** $2,600 per person $5,200 per family	$6,000 per person	**Medical:** $4,000 per person; $8,000 per family **Prescription drugs:** $2,600 per person $5,200 per family	$6,000 per person	**Medical:** $4,000 per person; $8,000 per family **Prescription drugs:** $2,600 per person $5,200 per family	$6,000 per person	**Medical:** $4,000 per person; $8,000 per family **Prescription drugs:** $2,600 per person $5,200 per family	$6,000 per person

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room with general nursing services. • Specialty care units within the hospital (e.g., intensive care unit). • Lab/x-ray/diagnostic services. • Medically Necessary ancillary services (e.g., prescriptions, supplies). • Newborn care.	**Elective Hospitalization requires preauthorization** to avoid a $200 penalty. Private room is covered only if Medically Necessary or if the facility does not provide semi-private rooms. The professional fees for Physicians are usually billed separately from the facility fee. Newborn eligible Dependents will be covered from the date of birth. However, it is very important that you request a new Enrollment Form within 60 days of the birth of your baby.	75%	50%	80%	60%	90%	50%	95%	80% for room and board and 100% for miscellaneous services
Physician Services The Plan covers services provided by Health Care Practitioners for either inpatient or outpatient consultations. Chiropractors, podiatrists, physical therapists, speech therapists and occupational therapists, and other Allied Health Care Practitioners are also covered.	• Under this Plan, there is no requirement to select a primary care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider. • No more than one visit is payable for any one provider on the same day.	75%	50%	80%	60%	90%	50%	95%	**Inpatient:** 80% **Outpatient:** 85%
Accident Expense Benefit		Not Applicable		Not Applicable		Not Applicable		100% of the first $500 of Allowed Charges within 90 days of an accident	

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Allergy Services The Plan covers allergy testing, serum and injections.		75%	50%	80%	60%	90%	50%	95%	85%
Ambulance Services The Plan covers: • Emergency transportation by local professional ambulance when the condition of the patient requires paramedic support. • Air ambulance only when the medical condition of the patient requires such transport to safely transport the patient to the nearest facility that can treat the injury or illness.	• You will not be balance billed for covered Non-PPO air ambulance services.	75%	**Ground Ambulance:** 50% **Air Ambulance:** 75%	80%	**Ground Ambulance:** 60% **Air Ambulance:** 80%	90%	**Ground Ambulance:** 50% **Air Ambulance:** 90%	95%	**Ground Ambulance:** 85% **Air Ambulance:** 95%
Chiropractic Services	Chiropractors, Physical Therapists, Speech Therapists, Occupational Therapists and Respiratory Therapists limited to 50 visits per accident or illness for all providers combined (increased to 60 visits in certain situations). Visit limits will not apply to diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice.	75%	50%	80%	60%	90%	50%	95%	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Dental Services • Accidental Injury to Teeth/Jaw	• Treatment of an accidental injury to the jaw or teeth is covered when treatment occurs within six months after the date of an accident, (applied without respect to when the individual is enrolled in the Plan). • Replacement of teeth is not covered under the medical plan.	75%	50%	80%	60%	90%	50%	95%	85%
Diabetes Training and Education	• Upon referral by the patient's physician, an approved Diabetes Self-Management Program is covered. The program must be directed by a Physician who specializes in the treatment of diabetes and is provided by licensed providers acting within the scope of their license.	100%, Deductible waived	50%	100%, Deductible waived	60%	100%, Deductible waived	50%	100%, Deductible waived	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Durable Medical Equipment (DME) Covered Expenses include rental (or purchase, if cost effective) of medically necessary durable medical equipment (DME), such as: • Hospital bed; • Wheelchair; or • Oxygen and other durable medical equipment used solely by the eligible individual for the treatment of illness or injury.	Coverage is provided for a standard manual or standard electric breast pump, plus the supplies needed to operate the breast pump. A hospital grade breast pump is payable if the Plan determines it to be medically necessary. The cost of renting or purchasing breastfeeding equipment extends for the duration of breastfeeding for the child.	**Breast Pump:** 100%, Deductible waived **All others**: 75%	50%	**Breast Pump**: 100%, Deductible waived **All others:** 80%	60%	**Breast Pump**: 100%, Deductible waived **All others:** 90%	50%	**Breast Pump:** 100%, Deductible waived **All others:** 95%	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Emergency Services Emergency services are covered: • Without the need for any prior authorization determination, even if the services are provided on a Non-PPO basis; • Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility; • Without imposing any administrative requirements or limitations on Non-PPO Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities.	• Services received at a hospital Emergency Room for treatment of an Emergency Medical Condition (as defined by the Plan) do not require prior certification. • If you receive Emergency Services in a PPO hospital from a non-PPO Physician, the Plan will pay the Physician services at the PPO level of benefits based on the lessor of billed charges from the provider or the Qualifying Payment Amount. • Your cost-sharing payments for Emergency Services (PPO or Non-PPO) will count toward any PPO out-of-pocket maximum.	**Emergency Room:** 75% **Urgent care:** 75%	**Emergency Room:** 75% **Urgent care:** 50%	**Emergency Room:** 80% **Urgent care:** 80%	**Emergency Room:** 80% **Urgent care:** 60%	**Emergency Room:** 90% **Urgent Care:** 90%	**Emergency Room:** 90% **Urgent Care:** 50%	**Emergency Room:** 100% **Urgent care:** 95%	**Emergency Room:** 100% **Urgent care:** 85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Family Planning, Reproductive, Fertility Services • Coverage is provided for FDA-approved female contraceptives such as oral birth control pills/patch, emergency contraception, injectables intrauterine device (IUD) and removal of IUD, cervical cap, contraceptive ring, diaphragm, implantable birth control device/service. • This benefit includes elective abortion for either the Employee or the Employee's Spouse but not for a Dependent child.	• No coverage for reversal of sterilization procedures. • Fertility and infertility services are payable for the diagnosis and treatment of medical conditions that result in infertility but not for expenses related to services that induce pregnancy including but not limited to surgical impregnation procedures like in-vitro fertilization • Coverage is provided without cost sharing for items and services integral to the furnishing of contraceptive services, such as anesthesia for a tubal ligation procedure or pregnancy tests needed before the provision of certain forms of contraception, such as an intrauterine device (IUD) regardless of whether the items and services are billed separately. • An exceptions process is available if an individual's health care provider recommends an item or service not covered under the plan's contraceptive coverage policies.	**Female contraceptives and female sterilization procedures:** 100%, Deductible waived **All other:** 75%	50%	**Female contraceptives and female sterilization procedures:** 100%, Deductible waived **All other:** 80%	60%	**Female contraceptives and female sterilization procedures:** 100%, Deductible waived **All other:** 90%	50%	**Female contraceptives and female sterilization procedures:** 100%, Deductible waived **All other:** 95%	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Home Health Care Covered Expenses include intermittent nursing care provided by a registered nurse or other licensed health care provider. The patient must be under the continuous care of a physician. Someone related to the patient by blood or marriage or otherwise residing in the patient's home is not considered to be a home health provider unless that person is a licensed health care provider.	• Home health care services require preauthorization to avoid a $200 penalty • Maximum benefit of 100 visits per calendar year. Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice. • Four hours of home health care aide services which consist primarily of medical or therapeutic caring for the patient, and are not primarily custodial in nature, will be considered one visit • Physical, occupational or speech therapy ordered by the patient's primary physician and provided by the Home Healthcare Agency are included in this benefit. • Medical supplies, infusion therapy and laboratory services provided by the Home Healthcare Agency are covered to the extent that these items would have been covered had the patient been hospitalized.	75%	50%	80%	60%	100% after Deductible	100% after Deductible	95%	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Hospice • Hospice services include inpatient hospice care and outpatient home hospice when Medically Necessary.	• Covered only when ordered by a Physician. • Inpatient hospice limited to a lifetime maximum of 60 days. Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice. • Bereavement counseling will be covered as an out-patient Mental Health benefit.	75%	50%	80%	60%	90%, Deductible waived	50%, Deductible waived	95%	85%
Laboratory Services (Outpatient) • Technical and professional fees.	• Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical • Some laboratory services are payable under the Wellness benefits in this Schedule. • A PSA test is covered once a year or as Medically Necessary.	75%	50%	80%	60%	90%	50%	No charge	No charge for first $1,000, then 80%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Maternity Services • Hospital and Birthing Center charges and professional fees for Medically Necessary maternity services. • Breastfeeding equipment (breast pump) and supplies needed to operate the pump are payable as preventive care services. • Comprehensive lactation support and counseling (including breastfeeding classes) when provided by a PPO provider. • Under federal law, plans may not require preauthorization or restrict benefits for any hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. The Plan may pay for a shorter stay if the attending Physician, after consultation with the mother, discharges the mother or newborn earlier.	• Pregnancy-related care is covered for a female employee or Spouse only. No coverage is provided for maternity expenses of Dependent children except for certain preventive care expenses required under ACA and Emergency Services under the No Surprises Act. • Prenatal and postnatal office visits obtained from a PPO provider are payable at no cost. Normal plan cost-sharing applies to all other maternity related services including ultrasounds and delivery fees. • **Elective induced abortion** is covered only for the Employee or Spouse.	**Breastfeeding support and counseling** 100%, Deductible waived **Prenatal office visit and ACA required preventive screenings:** No charge, Deductible waived. **All other:** 75%	50%	**Breastfeeding support and counseling** 100%, Deductible waived **Prenatal office visit and ACA required preventive screenings:** No charge, Deductible waived. **All other:** 80%	60%	**Breastfeeding support and counseling** 100%, Deductible waived **Prenatal office visit and ACA required preventive screenings:** No charge, Deductible waived **All other:** 90%	50%	**Breastfeeding support and counseling** 100%, Deductible waived **Prenatal office visit and ACA required preventive screenings:** No charge, Deductible waived **All other:** 95%	**Breastfeeding support and counseling** 85% **Prenatal office visit and ACA required preventive screenings:** 85% **Inpatient Hospital:** 80% for room and board and 100% for miscellaneous **All other**: 85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Medical Supply and Prosthetics Covered Expenses include: • Casts, splints, binders, braces, crutches, and surgical dressings. • Custom made orthotics that are Medically Necessary to treat a symptomatic disorder of the foot. • Blood, blood plasma, and its administration. • Oxygen and its administration. • Artificial limbs and eyes. • Breast prosthesis following a mastectomy and subsequent prosthesis when ordered by a physician. • Initial purchase of eyeglasses or contact lenses as a result of cataract surgery. • Hearing Aids, including fitting Prosthetic devices to restore a method of speaking incident to a laryngectomy (removal of the larynx or voice box) but not including electronic voice producing machines.	• Replacement of batteries or repairs of hearing aids are not covered.	75%	50%	80%	60%	90%	50%	95%	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Mental Health and Substance Abuse Treatment • **Inpatient hospital admission** and residential treatment programs. • **Outpatient visits** including partial day care/partial day treatment and intensive outpatient program (IOP)	• Elective inpatient admission to a hospital or residential treatment program requires preauthorization to avoid a $200 penalty	75%	50%	80%	60%	90%	50%	95%	**Inpatient Hospital:** 80% for room and board and 100% for miscellaneous **Outpatient**: 85%
Outpatient Hospital and Free Standing Surgical facility • Services provided by a hospital on an outpatient basis, including surgery for which you are not admitted to the hospital and you are discharged in 23 hours or less; • Diagnostic imaging, including MRIs and CT Scans; • Endoscopic procedures • Therapeutic radiation treatment • Professional fees are usually billed separately from the facility fee.		75%	50%	80%	60%	90%	50%	95%	85%
Radiation Therapy and Chemotherapy		75%	50%	80%	60%	90%	50%	95%	85%

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Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Radiology (X-Ray), and Imaging Services Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician. • Some radiology procedures are covered under the Preventive care benefits described in this Schedule.	75%	50%	80%	60%	90%	50%	No charge	No charge for first $1,000, then 80%
Rehabilitation Services (Physical, Occupational & Speech Therapy) • Short term **active, progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified Health Care Practitioner as ordered by a Physician. • Inpatient Rehabilitation Services in an acute Hospital, rehabilitation unit or facility or Skilled Nursing Facility for short term, **active, progressive** Rehab services **that cannot be provided in an outpatient or home setting.**	• Inpatient Rehabilitation admission requires preauthorization to avoid a $200 penalty. • Chiropractors, Physical Therapists, Speech Therapists, Occupational Therapists and Respiratory Therapists limited to 50 visits per accident or illness for all providers combined (increased to 60 visits in certain situations). Visit limits will not apply to diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice.	75%	50%	80%	60%	90%	50%	95%	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Skilled Nursing Facility (SNF) or Subacute Facility • Skilled Nursing Facility (SNF). • Subacute Care Facility, also called Long Term Acute Care (LTAC) Facility. • The professional fees for Physicians are usually billed separately.	• Admission to a Skilled nursing facility requires preauthorization to avoid a $200 penalty. • Skilled Nursing Facility confinement or Subacute care facility confinement is payable up to 100 days per calendar year. Visit limits will not apply to treatment of diagnosed mental health conditions or substance use disorders consistent with generally recognized independent standards of current medical practice.	100%, Deductible waived	100%, Deductible waived	100%, Deductible waived	100%, Deductible waived	100%, Deductible waived	100%, Deductible waived	95%, Deductible waived	85%, Deductible waived

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Smoking/Tobacco Cessation Benefits • This benefit can be used to help with nicotine addiction (to stop smoking or stop chewing tobacco).	Coverage includes screening for tobacco use; and, for those who use tobacco products, at least two tobacco cessation attempts per year. Cessation attempt includes coverage for: • Four (4) tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and individual counseling) without prior authorization; and • All FDA-approved tobacco cessation medications (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization.	100%, Deductible waived	50%	100%, Deductible waived	60%	100%, Deductible waived	50%	100%, Deductible waived	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

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THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Transplants (Organ and Tissue) •Coverage is provided only for eligible services directly related to Medically Necessary and non-experimental transplants of human organs or tissue.	• **Transplant services require preauthorization to avoid a $200 penalty.** • For plan participants who serve as a donor, **Donor Expenses**, including testing, related to any organ/tissue transplant procedure, unless the organ recipient is covered under this Plan and such expenses are not eligible for coverage under any other benefit plan, whether insured or not. All such costs must be approved in advance by Anthem.	75%	50%	80%	60%	90%	50%	95%	**Inpatient:** 80% for room and board and 100% for miscellaneous services **Outpatient:** 85%
Weight Management and Nutritional Counseling As a **preventive counseling benefit** in compliance with ACA, the Plan covers **intensive behavioral counseling interventions.**	•**Adults:** For adults with a body mass index of 30 or higher, up to a combined limit of 26 individual or group visits per year by a PPO provider. •**Children:** For children age 6 years and older with obesity, the Plan covers intensive behavioral counseling interventions to promote improvement in weight status at the visit frequency recommended by the child's Provider. •Diet drugs, appetite suppressants or other weight loss drugs are **not** covered.	100%, Deductible waived	50%	100%, Deductible waived	60%	100%, Deductible waived	50%	100%, Deductible waived	85%

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***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Please check your employer's Collective Bargaining Agreement to confirm your medical plan option.

THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Wellness (Preventive) Children - The Plan covers: •Well baby and well child visits through age 21; •Age appropriate screenings and behavioral assessments; •Childhood immunizations (including COVID-19); •For obese children age 6 and older, **intensive behavioral counseling** interventions as described in row titled "weight management". •Gonorrhea preventive medication for the eyes provided for the newborn during hospital confinement for birth; •I fluoride varnish applied to the primary teeth of children to age 5; •Counseling for children ages 10-24 years who have fair skin about reducing risk for skin cancer; •Tobacco education or brief counseling to prevent initiation of tobacco use in school aged children. Where the information in this document conflicts with ACA regulations affecting preventive care coverage, this Plan will comply with the requirements on the date required. Preventive services are payable without regard to gender assigned at birth, or current gender status. The frequency for ACA preventive service recommendation is specified in these websites*: https://www.healthcare.gov/what-are-my-preventive-care-benefits/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index*. The frequency of preventive visits for children is payable in accordance with the "Recommendations for Preventive Pediatric Health Care" from Bright Futures/American Academy of Pediatrics, updated periodically, (website for the schedule is*: https://www.aap.org/en-us/Documents/periodicity_schedule.pdf*). If these websites do not specify a frequency for which the preventive service should be performed, the Plan will pay for the preventive service when performed no more frequently than once a calendar year. Travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.		100%, Deductible waived	50%	100%, Deductible waived	60%	100%, Deductible waived	50%	100%, Deductible waived	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Please check your employer's Collective Bargaining Agreement to confirm your medical plan option.

THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Wellness (Preventive) Men - The Plan covers: • Immunizations as required under ACA (including COVID-19); • Screenings for alcohol misuse, chlamydia, diabetes, depression, obesity, HIV, blood pressure, cholesterol, Syphilis, hepatitis C, abdominal aortic aneurysm, lung cancer and Hepatitis B. • Tobacco use screening and 2 annual cessation interventions; • For overweight men, intensive behavioral counseling as outlined in row titled "weight loss". • Colorectal screening (including fecal occult blood testing, sigmoidoscopy or colonoscopy) for ages 45 and over. Where the information in this document conflicts with ACA regulations affecting preventive care coverage, this Plan will comply with the requirements on the date required. Preventive services are payable without regard to gender assigned at birth, or current gender status. The frequency for ACA preventive service recommendation is specified in these websites: *https://www.healthcare.gov/what-are-my-preventive-care-benefits/, http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index*. If these websites do not specify a frequency for which the preventive service should be performed, such as is the case for a preventive office visit or cholesterol screening, the Plan will pay for the preventive service when performed no more frequently than once a calendar year. Occupational immunizations are not covered. Also, travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.		100%, Deductible waived	50%	100%, Deductible waived	60%	100%, Deductible waived	50%	100%, Deductible waived	85%

MEDICAL BENEFITS SUMMARY (FOR PLANS 5, 5B, 6 AND 7)

***IMPORTANT: Non-PPO providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in balance billing to you.**

Please check your employer's Collective Bargaining Agreement to confirm your medical plan option.

THE SCHEDULE OF BENEFITS FOR PLANS 2, 3 AND 4 BEGINS ON PAGE 42

Benefit Description	Explanations and Limitations of Benefits	PLAN 5		PLAN 5B		PLAN 6		PLAN 7	
		PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO	PPO	Non-PPO
Wellness (Preventive) Woman – The Plan covers: • Well woman office visit; • Immunizations as required under ACA (including COVID-19); • Screenings for alcohol misuse, chlamydia, domestic violence, diabetes, lung cancer, depression, obesity, gonorrhea, HIV, blood pressure, cholesterol, HPV, osteoporosis, cervical cancer, Syphilis, hepatitis C and Hepatitis B. • For pregnant women, the following additional screenings: bacteriuria, gestational diabetes, Rh Incompatibility. • Tobacco use screening, 2 annual cessation interventions; • Counseling for domestic violence. • Sexually transmitted infection counseling if at increased risk. • For overweight women, intensive behavioral counseling as described in row titled "weight loss". • BCRA counseling and BCRA 1 or 2 genetic tests; • Breast cancer chemoprevention; • Mammogram for women ages 40 and older; • Contraceptive education, counseling and sterilization procedures. (Contraceptives are payable under the Family Planning Benefit); • Colorectal screening (including fecal occult blood testing, sigmoidoscopy or colonoscopy) for ages 45 and over. Where the information in this document conflicts with ACA regulations affecting preventive care coverage, this Plan will comply with the requirements on the date required. Preventive services are payable without regard to gender assigned at birth, or current gender status. The frequency for ACA preventive service recommendation is specified in these websites: *https://www.healthcare.gov/what-are-my-preventive-care-benefits/, http://www.hrsa.gov/womensguidelines/, and http://www.cdc.gov/vaccines/schedules/hcp/index.html, and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index*. If these websites do not specify a frequency for which the preventive service should be performed, the Plan will pay for the preventive service when performed no more frequently than once a calendar year. Occupational immunizations and travel immunizations, e.g., typhoid, yellow fever, cholera, plague, and Japanese encephalitis virus) are not covered.		100%, Deductible waived	50%	100%, Deductible waived	60%	100%, Deductible waived	50%	100%, Deductible waived	85%

ACCIDENT EXPENSE BENEFIT

If your Indemnity Medical Plan includes the accident expense benefit, it will be outlined in the ***Schedule of Medical Benefits***. If you are eligible for this benefit and you are injured in an accident, the Plan will pay first dollar benefits up to the amount shown in the ***Schedule of Medical Benefits.*** All Covered Expenses up to this amount will be paid in full. If your charges exceed this amount the Plan will pay regular benefits under the Indemnity Medical Plan, subject to your deductible and coinsurance.

The Supplemental Accident Benefits include:

- Medical and surgical treatment;
- Hospital services;
- Services provided by a registered nurse or physical therapist;
- Laboratory and x-ray services related to the accident;
- Injuries sustained to the teeth or gums related to the accident.

Exclusions and Limitations:

- Treatment beginning more than 90 days after the accident (applied without respect to when the individual is enrolled in the plan);
- Ptomaine poisoning (i.e. food poisoning);
- Disease or infections other than those related to the accident;
- Eyeglasses;
- Hearing aids;
- Injuries sustained in a mutual physical altercation.

PRESCRIPTION DRUG BENEFITS

As an eligible participant in the California Service Employees Health and Welfare Trust Fund, you and your eligible Dependents are covered under one of the Prescription Drug options **if your Collective Bargaining Agreement provides for this benefit and you are enrolled in the Indemnity Medical Plan.** OptumRx, a leading company in pharmacy benefit management, administers your prescription drug benefit program. If you are enrolled in Kaiser, your prescription drugs will be through Kaiser.

Retail Network Pharmacy Benefit

The Retail Network Pharmacy Benefit allows you to buy covered prescriptions you need immediately from any OptumRx pharmacy. To receive the most from your prescription card program, always present your prescription ID card along with your prescriptions at a participating network pharmacy.

Please review the **Summary of Prescription Drug Copays** on page 80. Our Plans do not provide for reimbursement of prescriptions obtained at non-contracted pharmacies, except in emergencies.

Your prescription will be filled for the exact quantity prescribed by your doctor, up to the supply limit. For example, if your prescription is written for a 30-day supply with 2 refills, you will receive a 30-day supply at one time. The refills cannot be combined to equal one 90-day supply. In addition, certain medications are subject to supply limits. If the prescription is written for more than the recommended quantity, the claim will be rejected at the pharmacy. The pharmacist will need to contact your doctor for direction.

When you use an OptumRx network pharmacy, there is no need to submit additional claim forms or paperwork. OptumRx works with the Trust Fund and network pharmacies to coordinate your prescription drug program. OptumRx also provides Customer Service Representatives (including Spanish speaking representatives) who can help answer any questions you or your pharmacist may have regarding your eligibility or prescription benefits.

If you have questions about your pharmacy benefit, call ***OptumRx Customer Service***, at the phone number on the back of your ID card, or call **(800) 797-9791 or 1-866-328-2005**, 24-hours a day - 7 days a week.

Mail Service Pharmacy Benefit

Maintenance Medications

The Mail Service Pharmacy Benefit allows you to obtain a 90-day supply of covered prescriptions used to treat chronic or long-term health conditions, such as high blood pressure, heart disease, diabetes, or asthma. Birth control pills are also considered maintenance medication. Covered prescriptions are conveniently delivered to your home.

Mandatory Mail Order Pharmacy

For some Plans, the Mail Service Pharmacy is required after you have obtained two (2) refills at retail (three purchases total). If this is the case under your plan, your ***Summary of Prescription Drug Copays*** outlined on page 80 will reflect this handling.

If you have questions about mail service, call ***Mail Service Customer Service*** at on the back of your ID card, or call **(800) 797-9791 or 1-866-328-2005**; 24-hours a day – 7 days a week.

Your Cost

Save Money by using Generic Drugs

Drugs have two names: a trademark or "brand" name, and a chemical or "generic" name. By law, brand and generic drugs must meet the same standards for safety and effectiveness. Many brand name prescriptions have a less expensive generic equivalent available. Using generic drugs whenever possible can save money for both you and your health and welfare plan.

Generic Substitution

It is standard pharmacy practice to substitute generic equivalent drugs for brand name drugs whenever possible. You will usually receive generic substitutes whenever possible, unless your doctor will not allow a generic substitution or you specify otherwise.

If there is a generic drug available and you choose to purchase the brand name drug, there are no benefits available for the brand name drug. This will apply **regardless of whether your Healthcare Practitioner writes "Dispense As Written" on the prescription.** You should always ask your doctor to prescribe generic drugs when they are available.

Prescription Drug Formularies

Certain prescription drug options use a formulary developed by OptumRx. The formulary list is a guide for you and your Healthcare Practitioner to choose appropriate, cost-effective medicines. Your Healthcare Practitioner, of course, will choose the medication you use, regardless of what is on the formulary. Choosing a formulary drug will help keep your out-of-pocket expense low. To find out if your prescription drug is on the formulary, check the OptumRx website, www.optumrx.com.

If your Prescription Drug Plan uses the OptumRx formulary, your ***Summary of Prescription Drug Copays*** will show three levels of copay. The lowest copay is for generic drugs, the middle level copay is for formulary brand name drugs and the highest copay is for non-formulary brand name drugs.

Summary of Prescription Drug Copays

There are **no benefits available for benefits purchased at Non-Network pharmacies or when you fail to present your OptumRx card at the time you purchase your drug at a network pharmacy.** The following table outlines your copays for covered prescription drugs purchased at a network pharmacy or ordered through the mail order program.

	Plan 1	Plan 5	Plan 6	Plan 8*
	In-Network	In-Network	In-Network	In-Network
Out-of-Pocket maximum	$2,600 Individual $5,200 Family	$2,600 Individual $5,200 Family	$2,600 Individual $5,200 Family	$2,600 Individual $5,200 Family

	Plan 1	Plan 5	Plan 6	Plan 8*
	In-Network	In-Network	In-Network	In-Network
Prescription Drugs Purchased at a Retail Pharmacy				
Generic Drugs	$2 copay	30%	$5 copay	$10 copay
Brand name Drugs	If no generic is available: $2 copay If generic is available, there are no benefits available for the brand name drug	If no generic is available: 50% copay If generic is available, there are no benefits available for the brand name drug	If no generic is available: $10 copay If generic is available, there are no benefits available for the brand name drug	If no generic is available: $20 copay If generic is available, there are no benefits available for the brand name drug
Non-Formulary Drug	Same Copays as Brand Name Drugs	Same Copays as Brand Name Drugs	If no generic is available: $35 copay If generic is available, there are no benefits available for the brand name drug	If no generic is available: $50 copay If generic is available, there are no benefits available for the brand name drug
Prescription Drugs purchased from a Mail Order Pharmacy				
Generic Drugs	No charge	30%	$10 copay	$20 copay
Brand Name Drugs	If no generic is available: No charge If generic is available, there are no benefits available for the brand name drug.	If no generic is available:50% If generic is available, there are no benefits available for the brand name drug.	If no generic is available: $20 copay If generic is available, there are no benefits available for the brand name drug.	If no generic is available: $40 copay If generic is available, there are no benefits available for the brand name drug.
Non-Formulary Drugs	Same copays as Brand Name Drugs	Same Copays as Brand Name Drugs	If no generic is available: $45 copay If generic is available, there are no benefits available for the brand name drug	If no generic is available: $65 copay If generic is available, there are no benefits available for the brand name drug

* ***Plan 8 requires that you obtain your maintenance medications through the mail order program. Any prescriptions that you take on a regular basis will no longer be filled at a retail pharmacy after the second refill.***

Prior Authorization Required for Some Medications

Prior authorization is a process that helps ensure that you receive the right care and the right drug to stay healthy. Prior authorization also helps ensure that the drug you have been prescribed is medically necessary. There may be another brand name or generic drug alternative available without prior authorization and with a lower copay.

Refer to your plan's Prescription Drug List (also known as a formulary) to see which drugs require prior authorization. All drugs, including strengths and formulations are shown on the formulary. Visit www.optumrx.com for the currently formulary.

The list is subject to change as new medications come on the market. Please call ***OptumRx Customer Service*** at **(800) 797-9791 or call the number on the back of your ID card** to find out if your medication is on the list. To begin the prior authorization process, your doctor can:

- Call OptumRx at the toll-free member phone number on the back of your ID card
- Fax a completed prior authorization form available on **optumrx.com** to OptumRx
- Submit the information through the online provider portal at **optumrx.com**

Your Health Care Practitioner must call the ***OptumRx Prior Authorization Department***, at the number on the back of your ID card or call **(800)** 711-4555, Monday through Friday 6:00 a.m. to 6:00 p.m. (Pacific Time) closed Saturday and Sunday. This number is for Health Care Practitioners' use only.

"NEW-TO-MARKET" DRUGS

Any medication that is newly approved by the U.S. Food and Drug Administration (FDA) to enter the market is not covered by the Fund until after OptumRx has had a chance to review the evidence and overall clinical value when compared to other alternatives in the market. This review will happen within six months of the FDA approval. This means that if you attempt to fill a prescription for one of these "new to market" drugs before OptumRx has completed its review, there will be no payment by the Fund.

PREFERRED ALTERNATIVE DRUGS

Within each drug category, there are many therapeutic alternative drugs available. If you are taking a prescription drug for one of the Therapeutic Categories listed in the attached document, the Fund will only provide coverage for the Preferred Alternative. If you attempt to fill a prescription for one of the "Excluded Medications", there will be no payment by the Fund. This does not mean you should stop taking your medication. We recommend that you talk to your doctor to discuss alternative medication options.

Appeals

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

Step Therapy

Under Step Therapy, you may be required to try a Preferred Medication before the Fund will cover the Non-Preferred medication. Please contact OptumRx for a complete Prescription Drug List (PDL) and drugs that are subject to the Step Therapy program.

Eight Weeks Therapy Maximum for Proton Pump Inhibitors

Proton Pump Inhibitors (PPIs) are used to treat conditions that are caused by too much stomach acid. PPI therapy is limited to the FDA recommendation of 8 weeks for several common acute conditions. After 8 weeks of therapy, prior authorization is required for continued coverage to treat chronic conditions. This requirement will be waived under certain conditions if you are under the care of a gastroenterology specialist. The

following medications are currently limited to eight weeks of therapy: Aciphex, Nexium, Omeprazole, Prevacid, Prilosec, Protonix and Zegerid.

Covered Drugs

The following items are covered under the prescription drug plan, unless specified under "Drugs Not Covered":

- Federal legend drugs (that is, drugs that federal law prohibits dispensing without a prescription).
- Compound prescriptions containing at least one legend ingredient.
- Insulin and disposable insulin syringes/needles
- Oral contraceptives (including contraceptives prescribed by a Pharmacist)
- Oral drugs for sexual dysfunction (regardless of cause) are covered subject a limit of ten per refill at retail and 30 per refill from mail order.

Preventive Care Drugs

Please note: Some of the Collective Bargaining Units do not provide any prescription drug benefits through the Fund (including Ralph's Grocery Company, Von's Grocery Company and Albertson's/Lucky's, Gelson's Company, Super A Foods or Stater Brothers). One of the requirements of ACA is that non-grandfathered plans like ours must provide coverage for certain preventive care drugs if a prescription is received. The absence of a prescription drug program does not exempt a plan from the ACA requirements. Therefore, any preventive care drugs that are required to be covered under ACA will be covered under the Indemnity Medical Plan for these bargaining units.

If your Health Care Practitioner writes a prescription and you obtain the drug at an In-Network Pharmacy, the following preventive care generic drugs are covered (either through the OptumRx or the Indemnity Medical Plan) in accordance with ACA regulations and the US Preventive Service Task Force (USPSTF) A and B recommendations.

PREVENTIVE CARE DRUG	DESCRIPTION OF BENEFITS AVAILABLE
Aspirin	Low-dose aspirin to prevent cardiovascular disease and colorectal cancer when prescribed by a health care provider, in adults ages 50 to 59 years who have a 10% or greater 10-year cardiovascular disease (CVD) risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years. Allow 1 bottle of 100 tablets every 3 months. Also, allow low dose OTC aspirin for women after 12 weeks of gestation who are at high risk for preeclampsia.
Fluoride	Allow prescription and over-the-counter oral fluoride supplements for ages 6 months to 6 years with no cost sharing if a prescription is received.
Folic Acid	Allow over-the-counter folic acid supplements including prenatal vitamins for women less than 55 years of age.
Preparation "prep" Products for a Colon Cancer Screening Test	Allow for adults over age 50 and under age 75. Allow generic only. Coverage is limited to 2 per 365 days.

PREVENTIVE CARE DRUG	DESCRIPTION OF BENEFITS AVAILABLE
Tobacco cessation products	All FDA-approved generic tobacco cessation medications (including both prescription and over-the-counter medications) for two 90-day treatment regimens annually.
Contraceptives for women	Generic FDA approved contraceptives for females (or brand drug if generic is medically inappropriate) An exceptions process is available if an individual's health care provider recommends an item or service not covered under the plan's contraceptive coverage policies.
Over-the-Counter contraceptives for women (such as spermicidal products and sponges)	OTC contraceptives for women (subject to quantity limits).
Statin preventive medication	Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater. Brand medications are payable only if a generic alternative is medically inappropriate as determined by the person's own health care provider
Breast cancer preventive medication (e.g. Tamoxifen, Raloxifene or aromatase inhibitors)	Women who are at increased risk for breast cancer and at low risk for adverse medication effects. Brand medications are payable only if a generic alternative is medically inappropriate as determined by the person's own health care provider
Pre-exposure Prophylaxis (PrEP)	For individuals with increased risk of HIV acquisition, allow generic FDA approved version of PrEP. Brand medications are payable only if a generic alternative is medically inappropriate as determined by the person's own health care provider

*Where the information in this document conflicts with ACA regulations affecting the coverage of OTC drugs, the Fund will comply with the requirements on the date required.

For Collective Bargaining Units that do not provide any prescription drug benefits through the Fund, you must submit the following information to the Administrative Office in order to have one of the above referenced drugs reimbursed:

- A claim form; and
- A prescription from your Health Care Practitioner showing the medical necessity for the drug.

Drugs Not Covered

Prescriptions submitted for items not covered will be returned to you unfilled. The following items are not covered under the plan.

1) Over-the-counter items that do not require a prescription (except insulin or as otherwise required under ACA).
2) Devices, appliances, and supplies other than insulin syringes and needles.
3) Any administration charge for the injection of any drug.
4) Prescriptions dispensed by a hospital or similar institution during confinement.
5) Prescriptions due to work related injury or illness.
6) Diet drugs, appetite suppressants or other weight loss drugs.
7) Minoxidil / Rogaine (for hair growth), Retin-A for any person over age 19, or any other prescription that is elective or for cosmetic purposes.
8) Prescription dispensed outside the United States except for emergencies.

9) Any drug considered by the Plan to be experimental or investigational (see ***Glossary of Defined Terms***).

Prescriptions Filled at Non-Network Pharmacies

With the large network of OptumRx participating pharmacies, you should have no problem finding a network pharmacy in your area. In fact, our Plans do not provide for any reimbursement of claims purchased at non-contracted pharmacies. If you need help finding a participating pharmacy, call OptumRx at the number listed on the Quick Reference Chart at the beginning of this SPD.

If you have a covered prescription filled at a non-network pharmacy, you will need to pay for the full cost of the prescription and send a claim to Optum Rx for reimbursement at the address listed on the Quick Reference Chart at the beginning of this SPD. You will be reimbursed the amount the Plan would have been charged if you had obtained the prescription at a network pharmacy, minus your applicable copay or coinsurance.

BriovaRx Specialty Pharmacy and Clinical Management Program for Specialty Pharmacy Users.

You have the option to use OptumRx/Briova Rx Specialty Pharmacy as your Plan's provider for specialty medications. Specialty Drugs are very high cost prescriptions that can include some injectables, inhalants and oral medications. Specialty drugs can be filled using the OptumRx/ Briova Rx Specialty Mail Order Pharmacy. Shipping is at no charge to you for your 30-day supply.

OptumRx/BriovaRx clinical pharmacists, who specialize in specialty therapies, are also available twenty-four hours a day, seven days a week to answer your specialty medication questions. These pharmacists and nurses are available for first-fill consultations as well as assisting with enrollment in clinical management if needed. Some benefits under Specialty Pharmacy may require prior authorization. Prior authorization ensures clinically appropriate prescribing. If you have any questions, please call the specialty team at 1-866-218-5445 or 1-855-4BRIOVA.

The OptumRx/BriovaRx pharmacy provides ongoing support through phone and online. BriovaCommunity™ provides customized online videos to help members better understand their condition. BriovaLive™ allows members to participate in a video chat via a secure setting with a registered pharmacist. Talk to your clinical pharmacist or go online to www.briovaRx.com for additional information.

To help members better manage their condition, the Clinical Management Program (CMP) provides extra support at no cost to individuals with a condition requiring specialty medications. Members who enroll in a CMP will receive regularly scheduled phone calls with a personal clinician. These calls focus on helping members to better understand their condition and medications, teach ways to manage side effects, and provide other resources to help patients take a more active role in their treatment. Participation is completely voluntary.

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

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

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

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

Caution for Retirees Regarding Enrollment in Medicare Prescription Drug Plans

If you are eligible for prescription drug benefits from either Kaiser or the Indemnity Prescription Drug Plan, the benefits provided are considered “Creditable Coverage” under Medicare Part D.

If you are in the Indemnity Prescription Drug Plan, and you DROP your prescription drug coverage with the Trust Fund and enroll in an individual Medicare Prescription Drug Plan or Medicare Advantage plan with prescription drugs, you will not be able to re-enroll for prescription benefit from this Trust Fund at a later date. Please refer to the information about coordination of prescription benefits with Medicare beginning on page 117.

SUMMARY OF VISION PLAN BENEFITS

Vision benefits are treated as a standalone (or excepted) benefit under HIPAA and the PPACA. However, the Fund has decided to cover Dependent children up to age 26 even though it is not required to do so.

You must refer to the Collective Bargaining Agreement or Subscriber Agreement with your Employer to determine if you are eligible to enroll in the Choice Plan or the Signature Plan.

Note: If you are eligible for and obtain Plan Benefits from a Non-VSP Provider, you should pay the provider's full fee. You will be reimbursed by VSP in accordance with the Non-VSP Provider reimbursement schedule shown above, less any applicable Copays.

Service	Choice Network VSP Provider	Non-VSP Provider (maximum reimbursement)	Signature Network VSP Provider	Non-VSP Provider (maximum reimbursement)
Copay	$10 copay (on first service received)	Not applicable	$5 copay (on first service received)	Not applicable
Exam Every:	12 months	12 months	12 months	12 months
Lenses Every:	12 months*	12 months*	12 months*	12 months*
Frame Every:	24 months	24 months	24 months	24 months
Examination	Covered after copay	Up to $50	Covered after copay	Up to $45
Lenses:				
Single Vision	Covered after copay	Up to $50	Covered after copay	Up to $30
Lined Bifocal	Covered after copay	Up to $75	Covered after copay	Up to $50
Lined Trifocal	Covered after copay	Up to $100	Covered after copay	Up to $65
Lenticular	Covered after copay	Up to $125	Covered after copay	Up to $100
Frames	$150	Up to $70	$150	Up to $70
Elective Contact Lenses*	$130	Up to $105	$130	Up to $105
Necessary Contact Lenses*	Covered after copay	Up to $210	Covered after copay	Up to $210
Discounts & Savings	Average 20%-25% savings on all non-covered lens options	Not applicable	Average 35%-40% savings on all non-covered lens options	Not applicable

*Contact Lenses are in lieu of glasses (lenses and frames).

Exclusions and Limitations

The vision plan is designed to cover *visual* needs rather than *cosmetic* materials. If you select any of the following extras, this Plan will pay only the basic cost of the allowed lenses or frames. However, you will be eligible for discounts as outlined in the chart above.

- Optional cosmetic processes.

- Anti-reflective coating.
- Color coating.
- Mirror coating.
- Scratch coating.
- Blended lenses.
- Cosmetic lenses.
- Laminated lenses.
- Oversize lenses.
- Progressive multifocal lenses.
- UV (ultraviolet) protected lenses.
- Certain limitations on low vision care.

Not Covered

There are no benefits available for professional services or materials connected with:

- Orthoptics or vision training and any associated supplemental testing; plano lenses (less than ±.50 diopter power); or two pair of glasses in lieu of bifocals.
- Replacement of lenses and frames furnished under this plan which are lost or broken except at the normal intervals when services are otherwise available.
- Medical or surgical treatment of the eyes.
- Corrective vision treatment of an Experimental Nature.
- Costs for services and/or materials above Plan Benefit allowances indicated on the enclosed insert.
- Services/materials not indicated as covered Plan Benefits on the enclosed insert.

SUMMARY OF INDEMNITY DENTAL PLAN BENEFITS

The Fund's dental plan benefits are an "excepted benefit" under HIPAA and PPACA and certain requirements do not apply to them. The Fund provides dependent children with coverage up to age 26 with dental benefits, but otherwise observes the excepted benefits rules.

You must refer to the Collective Bargaining Agreement or Subscriber Agreement with your Employer to determine if you are eligible to enroll in one of the Indemnity Dental Plans. You may also have a choice of a pre-paid dental plan. If you are enrolled in a pre-paid dental plan, you will be provided with an evidence of coverage from the dental plan.

The following four self-funded dental plans are offered by the Trust Fund which are outlined in this chapter of the SPD, and are for the purpose of collective bargaining between your Employer and Union. Please check with your Union's collective bargaining agreement (contract) for the plan that was agreed to by the parties, which may not be any of these optional plans.

- Self-funded Plan I;
- Self-funded Plan IV;
- Self-funded Plan VI; or
- Self-funded Plan VII.

Dental Network

The Fund contracts with First Dental Health (FDH) who have a network of dental providers who extend a discount to you for covered dental services.

If you choose to use a dentist that is not part of the FDH network, you may be balanced billed for any amounts over the Allowed Charge.

Definitions

The term "**Calendar Year**" means the twelve-month period beginning on January 1 and ending at midnight on December 31 of each year.

The term "**Covered Dental Expense**" means only expenses incurred for necessary treatment which is received by an Eligible Individual from a Dentist, or a dental hygienist under the supervision of a Dentist, and which, in the geographical area where treatment is rendered, is the usual and customary procedure for the condition being treated. A Covered Dental Expense is deemed to be incurred on the date on which the service or supply which gives rise to the expense is rendered or obtained.

The term "**Dental Consultant**" means a Dentist who reviews and advises the Board of Trustees on dental procedures submitted to the Claims Administration Office by another Dentist.

The term "**Fee Schedules**" means the description of dental procedures and the amount allowable for each procedure as approved by the Board of Trustees, and amended from time to time.

Preauthorization Requirement

We recommend that you submit any claims for dental treatment that will cost $500 or more in charges to the Claims Administration Office **for prior authorization of benefits before treatment begins.** While this preauthorization is not required, it is strongly recommended in order to help you avoid any unexpected out-of-pocket amounts.

Prior authorization or predetermination of benefits allows you to know which services are covered and the extent of the benefits to be allowed for the treatment performed ***before*** the work is done. If you, or one of your family, plan to have dental treatment in excess of $500.00, you should ask your dentist to file for prior authorization. This will assure that both you and your dentist will know in advance what part of the treatment plan will be covered to the extent of the benefits paid by the plan. Here's how it works:

- The dentist informs the Trust Fund Office of the proposed treatment plan by itemizing all services and charges on the claim form which you provide to the dentist.
- The Trust Fund Office then determines the amount the plan will pay and informs you and the dentist of its decision. You and your dentist should discuss these results before treatment is started.

Predetermination of benefits will help you avoid unpleasant surprises. Most dentists are familiar with predetermination procedures.

If you do not request Prior Authorization the plan will pay benefits based on whatever information it has available. Predetermination of benefits could save you money (See Section on Alternate Procedures).

Alternate Procedures

Often there is more than one way to treat a specific problem. For example: either a crown or amalgam filling could be used to restore a particular tooth. Also, choices can be made regarding materials to be used, precious metal or plastics. The plan will pay benefits for the lower amount provided the treatment is professionally acceptable. In all cases, where the Alternative Procedures provision is applicable, the claim will be reviewed by the Plan's dental consultant who is a licensed dentist.

The Prior Authorization provision of the plan is important because under the "Alternate Procedures" provisions, the Plan has the right to pay the scheduled amount for the "least expensive," professionally acceptable treatment.

If you and your dentist choose a more costly treatment than allowed by the Plan, then you would be responsible for those charges in excess of benefits for the least costly treatment, as determined by the Trust Fund.

Dental Benefits

The self-funded dental plans pay benefits based on a percentage of a schedule of allowances up to a maximum calendar year benefit. In addition, there is an orthodontic benefit with a lifetime maximum benefit. The following table provides a brief summary of the benefits under each option:

	Dental Benefits			Orthodontic Benefits	
	Deductible	Coinsurance	Calendar Year Maximum *	Coinsurance	Lifetime Maximum
Self-funded Plan I	$0	80%	$3,000	50%	$2,000
Self-funded Plan IV	$0	80%	$5,000	80%	$3,000
Self-funded Plan VI	$50	90% ***Diagnostic and Preventive Services*** 80% ***Basic Services*** 50% ***Major Services***	$2,500	50%	$2,000
Self-funded Plan VII	$75	70%	$3,000	50%	$1,500

* The calendar year maximums do not apply to children up to age 19.

Schedule of Services

Subject to the Limitations and Exclusions set forth below, the Schedule of Services are covered when rendered by a Dentist, or a dental hygienist under the supervision of a Dentist, and when determined to be an Allowed Charge.

A) Necessary procedures to assist the Dentist in ***evaluating the existing conditions*** to determine the required dental treatment.

> Full mouth x-rays are limited to one set every 36 consecutive months;

> Bitewing x-rays are limited to one set every six consecutive months

B) ***Preventive Care***: Necessary procedures to prevent the occurrence of oral disease. These services include:

1. Prophylaxis, not to exceed three per calendar year;
2. Topical application of fluoride solutions;
3. Initial Exam – once every 12 months and periodic exam once every six months.
4. Sealants on molars without restorations up to age 14;
5. Space maintainers (not related to orthodontic treatment).

C) ***Oral Surgery:*** Necessary procedures for extractions and oral dental surgery including pre- and post-operative care.

D) ***Restorative Dentistry:*** Necessary procedures for amalgam, synthetic porcelain and plastic restorations. Gold restorations, crowns and jackets shall be provided when teeth cannot be restored with the above materials.

E) ***Endodontics:*** Necessary pulpal therapy and root canal filling (treatment of non-vital teeth).

F) ***Periodontics:*** Necessary procedures for treatment of the tissues supporting the teeth.

G) ***Prosthodontics:*** Necessary procedures for construction of bridges, partial and complete dentures. Replacement will be allowed every five (5) years if deemed necessary. This applies to the existing crowns and prosthetics.

H) ***Orthodontics:*** Necessary procedures and appliances for the interception and treatment of malocclusion of the teeth and their supporting structures. Benefits will be paid in equal monthly installments for the duration of the treatment plan submitted by the attending Orthodontist. The provider must submit a bill monthly.

Limitations and Exclusions.

A) Services for injuries or conditions which are compensable under Worker's Compensation or Employer's Liability Laws, services provided by any Federal or State Government Agency, (service related), or provided without cost by any municipality, county or other political subdivision are not covered services.

B) Services with respect to congenital malformations or cosmetic surgery or dentistry for purely cosmetic reasons are not covered services.

C) Crowns placed on molars shall receive the allowance of full cast crowns, as porcelain crowns are considered cosmetic in this area. (Build-up under a crown shall be included in the cost of the crown.)

D) Oral hygiene instruction, plaque control, nutritional and tobacco counseling, periocharting and fee for completion of claim form are not covered services. Please note that nutritional and tobacco counseling benefits are available under the preventive care benefits of the medical plan.

E) Prosthetics and crowns which were paid for by this Plan are limited to replacement once every five years and only if deemed necessary.

F) Procedures, appliances or restorations solely for aesthetic purposes are not covered benefits.

G) Procedures, appliances or restorations that the Dental Consultant deems unnecessary may be disallowed.

H) Periodontal root planing is limited to four (4) quadrants in 24 months.

I) Elective or optional procedures may be disallowed by the Dental Consultant.

J) Posterior composite restorations will not be allowed. Allowance will be made for amalgam restorations on posterior teeth.

K) Space maintainers for primary teeth are subject to approval by the Dental Consultant.

L) Crown build-up and/or gingival surgery, and construction of temporaries are to be included in the fee for the crown.

M) Temporomandibular Joint Syndrome (TMJ) associated procedures are not covered benefits.

N) Implants, new and/or pre-existing and all related and attendant services are not covered benefits.

O) Expenses incurred for appliances or restorations necessary to increase vertical dimension or restore occlusion or for the purpose of splinting are not covered.

P) Any dental treatment rendered out of the United States and its territories shall be limited to emergency treatment and reviewed by the Trust Funds' Dental Consultant and will be denied if not consistent with California standards.

Q) If an Eligible Individual selects a more expensive program of treatment than is customarily provided, or specialized techniques rather than standard procedures, benefits shall be payable for the least expensive plan of treatment, provided the treatment is professionally acceptable.

R) Any experimental dental procedure. A procedure is considered as experimental when there is no consensus in the professional dental community on the safety or effectiveness of the procedure, there is insufficient evidence to determine its appropriateness, or if use of the procedure for the given indication in the specified patient population is confined largely to research protocols.

Extended Dental Benefits

If a dental procedure is initiated prior to an Eligible Individual's termination of eligibility, dental benefits for that procedure shall be provided until the earliest of the following dates:

A) the end of two calendar months from the date eligibility was terminated: or

B) the date of completion of the specific course of dental treatment.

LIFE INSURANCE/ACCIDENTAL DEATH & DISMEMBERMENT

As an eligible participant in the California Service Employees Health and Welfare Trust Fund, you and your eligible Dependents (up to age 26) are covered under this Life Insurance Benefit plan if your ***Collective Bargaining Agreement*** provides for this benefit. The amount of life insurance available depends on the option/class that your contributing employer has negotiated for.

Class	Employee Life Insurance Amount	Dependent Life Insurance Amount
Class 1	$1,000	Not Covered
Class 2	$3,000	Not Covered
Class 3	$5,000	$2,500
Class 4	$8,000	$2,500
Class 5	$10,000	$2,500
Class 6	$40,000	$2,500
Class 7	$50,000	$2,500
Class 10	$20,000	Not Covered
Class 11	$10,000	Not Covered
Class 12	$20,000	$10,000
Class 13	$30,000	$10,000

Your Beneficiary

Your beneficiary is the person that you name to receive the proceeds of the life insurance policy. If there is no eligible beneficiary or if you did not name one, benefits will be paid in the following order. Your –

- Spouse or domestic partner
- Natural and adopted children
- Parents
- Brothers and sisters
- Estate

You may request a change of beneficiary at any time by submitting a new beneficiary form to the Fund Office. A change in beneficiary will take effect as of the date it is signed by you but will not affect any payment the insurance company makes or action it takes before receiving your notice.

Accelerated Death Benefit in Case of Terminal Illness

If it is determined that you have a terminal condition and have a life expectancy of 6 months or less, 50% of your life insurance benefit may be paid to you or your legal representative while you are still living. The Accelerated Benefit applies to Employee Life Insurance only – not to Dependent Life Insurance.

The benefit is paid in one lump sum and is paid only once. This lump sum payout is the only benefit option available to you prior to your death. You must have at least $10,000 in life insurance to qualify for this benefit.

Accelerated benefits will not be paid for a terminal condition if either of the following apply:

- The terminal condition is directly or indirectly caused by attempted suicide or intentionally self-inflicted Injury, whether sane or insane; or
- The required Life Insurance premium is due and unpaid.

Your life insurance benefit is reduced by the amount paid out to you as an accelerated benefit.

Waiver of Life Insurance Premium During Disability

Your life insurance will stay in effect if you become Totally Disabled before you reach age 60 and while you are eligible under this Plan. Your coverage may be continued without any further premium payment so long as the total disability continues and the required proof is submitted to the insurance company, as explained below. This is called a Waiver of Premium.

For purposes of this benefit, "Totally Disabled" means that you are unable, due to sickness or accidental Injury, to work at or perform the material and substantial duties of any job suited to your education, training or experience. You must be continuously Totally Disabled for at least 9 months before you are eligible for the waiver of premium.

The waiver of premium includes life insurance only. It does not include accidental death and dismemberment (AD&D) insurance or dependents' life insurance.

Life Insurance for Dependents

The life insurance amounts shown in the following chart are payable if one of your eligible dependents dies from any cause while insured under the Plan. The amount of the benefit depends on whether the deceased was your spouse or domestic partner or a child.

Dependent	Life Insurance Amount
Spouse or Domestic Partner	$2,500
Children	$2,500
Spouse/Domestic Partner and/or Children covered under the Maintenance Contractors Agreement (MCA)	$10,000

Accidental Death & Dismemberment (AD&D)

The accidental death and dismemberment (AD&D) benefit will be paid if you lose your life, limb or sight due to an accident. All of the following conditions must be met:

- You are insured on the date of the accident,
- The loss occurs within 180 days after the accident, and
- The cause of the loss is not excluded.

Schedule of Benefits

The payment for all losses caused by any one accident will never be more than the 100% of your life insurance amount (which depends on the option/class that your contributing employer has negotiated for).

AD&D Loss	Percentage of Life Insurance Amount
Loss of life	100%
Loss of both hands, both feet or sight of both eyes	100%
Loss of one hand and one foot	100%
Loss of speech and hearing in both ears	100%
Loss of one hand or one foot and sight of one eye	100%
Loss of one hand or one foot or sight of one eye	50%
Loss of speech	25%
Loss of hearing in both ears	25%
Loss of thumb and index finger of same hand	25%

Accidental Death and Dismemberment Exclusions

No benefit will be paid for any loss that is caused directly or indirectly by any of the following:

- Suicide or intentionally self-inflicted Injury, while sane or insane.
- Physical or mental Illness.
- Bacterial infection or bacterial poisoning. **Exception:** Infection from a cut or wound caused by an accident.
- Riding in or descending from an aircraft as a pilot or crew member.
- Any armed conflict, whether declared as war or not, involving any country or government.
- Injury suffered while in the military service for any country or government.
- Injury which occurs when you commit or attempt to commit a felony.
- Use of any drug, narcotic or hallucinogenic agent:
    - unless prescribed by a Healthcare Practitioner,
    - which is illegal,
    - which is not taken as directed by a Healthcare Practitioner or the manufacturer.
- Your intoxication. Intoxication means your blood alcohol content meets or exceeds the legal presumption of intoxication under the laws of the state where the accident occurred.

Right to Convert to an Individual Policy

During the 31-day period following termination of your eligibility (or your dependent's eligibility), you or your insured dependent may convert this life insurance (excluding any amount paid out as an accelerated death benefit) to an individual policy.

Proof of good health is not required to convert your insurance to an individual policy. You must apply for the individual policy and pay the first premium within 31 days of the date your eligibility ends.

If you wish to convert your coverage to an individual policy, contact the Fund Office or the insurance company at the address on the Quick Reference Chart.

How to File a Life Insurance Claim

Send claims to the Fund Office which will confirm eligibility and forward the claim to the insurance company. Payment of the claim will be made by the ReliaStar Life Insurance Company promptly upon receipt of all necessary proof from the Fund Office.

Whenever there is a death claim, obtain a life insurance claim form from the Fund Office. The completed claim form, along with a certified copy of the death certificate, should be sent to the Fund Office at the address on the Quick Reference Chart.

The Fund Office will confirm eligibility and forward the claim to the insurance company. The insurance company will pay the claim promptly upon receipt of all necessary proof.

Appeals of Denied Life Insurance Claims

See "Claims and Appeals Procedures" in this booklet for information on how to file an appeal

GENERAL EXCLUSIONS AND LIMITATIONS

Although the Indemnity Medical Plan covers many services and supplies, it does not cover everything. The following is a list of expenses that are not covered under either the Indemnity Medical Plan, the Indemnity Prescription Drug Plan or the Indemnity Dental Plan.

1) Except as specifically provided for, any services or supplies that are not **Medically Necessary** as determined by the Plan (refer to the ***Glossary of Defined Terms***).
2) Charges in excess of the Allowed Charge (refer to the Glossary of Defined Terms).
3) Charges determined by the Plan to be Experimental or Investigational (refer to the Glossary of Defined Terms).
4) Any charges incurred while the person is not eligible under the Plan.
5) Dental services and supplies are not covered under the medical plan, except treatment of an accidental injury to the 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. Replacement of teeth is not covered under the medical plan.
6) Accidental bodily injury or sickness arising out of, or in the course of, employment, including self-employment. This Plan does not provide benefits if the expenses are covered by workers' compensation or occupational disease law, whether or not a claim is filed. If the individual's employer contests the application of workers' compensation law for the illness or injury for which expenses are incurred, this Plan may pay benefits, subject to its right to recover those payments if and when it is determined that they are covered under a workers' compensation or occupational disease law. However, before such payment will be made, the individual must execute a subrogation and reimbursement agreement, which will be provided by the Fund Office (refer to Subrogation and Reimbursement, page 119).
7) Any expenses for which a third party is responsible (refer to Subrogation and Reimbursement, page 119).
8) Services and supplies furnished by any person, hospital or other provider organization who or which, regardless of the patient's financial ability, does not require payment in any amount from the patient.
9) 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 for non-service connected conditions under 38 U.S.C. 629.
10) Any charges made by a hospital for personal comfort items, such as telephone or television or any charges for completion of forms or for broken appointments.
11) Cosmetic surgery or treatment, except for repair of damage caused by accidental bodily injury or as required by the Women's Health and Cancer Rights Act of 1998 or treatment of a child from birth to correct a congenital anomaly, including an oral defect. Restorative surgery performed during or following mutilative surgery, which was required as a result of illness or injury, shall not be considered cosmetic.
12) Donor Expenses, including testing, related to any organ/tissue transplant procedure, unless the organ recipient is covered under this Plan and such expenses are not

eligible for coverage under any other benefit plan, whether insured or not. All such costs must be approved in advance by the Case Manager at Anthem Blue Cross.

13) Educational services: Such as auditory or speech aids (including computers, computer devices/software, printers, books, tutoring or interpreters, visual aids, vision therapy, synthesizers, auxiliary aids such as communication boards, and listening systems), auditory perception or listening/learning skills and/or programs and services to remedy or enhance concentration, memory, motivation, reading or self-esteem. This exclusion does not apply to the hearing aid benefit as specifically provided for in the Indemnity Medical Plan.

14) Recreational or leisure therapy.

15) Vocational testing or counseling.

16) Injuries or illness resulting from any form of warfare or invasion or while on active duty with the Uniformed Services of any country.

17) Injuries or illness resulting from participation in a riot or the commission of a felony unless such injury or illness is the result of domestic violence or the commission of the felony is the direct result of an underlying health factor.

18) The Plan does not cover treatment received from a relative by blood or marriage or a person who resides in the patient's household, unless such person is providing treatment in accordance with a valid license issued under state law.

19) Genetic testing and counseling except as a required preventive service in accordance with ACA regulations.

20) Services and supplies not recommended, approved, and prescribed by a Health Care Practitioner acting within the scope of their license (except for preventive care services required under ACA).

21) Orthopedic shoes or other wearing apparel.

22) Vitamins, health foods, supplements, consultations regarding food or nutrition, except for diabetic training and education or as a required preventive service in accordance with ACA regulations or when prescribed in connection with treatment of an eating disorder..

23) Exercise equipment, whirlpools, Jacuzzis, air purifiers, saunas, pillows, and other non-prescription items for personal use, whether or not prescribed by a Health Care Practitioner.

24) Eye refractions and any surgical procedure to correct refractive errors of the eye; or eyeglasses or contact lenses except as required immediately following and as a result of cataract surgery or as specifically provided for under the Vision Service Plan benefit if your employer has bargained for vision benefits.

25) Custodial care (refer to the Glossary of Defined Terms).

26) Reversal of sterilization or any treatment, service or drug for treatment of infertility (except for services to diagnose the condition as specifically provided in the Schedule of Medical Benefits).

27) Maternity services for a Dependent Child except complication thereof or as a required preventive service in accordance with ACA regulations or Emergency Services under the No Surprises Act.

28) Charges related to the treatment of obesity which is not the result of an underlying psychological disorder, other than surgical intervention for morbid obesity (as determined by Anthem) or as a required preventive service in accordance with ACA regulations. If your provider prescribes surgical intervention, prior authorization from Anthem Blue Cross is required.

29) All services and charges related to a Xenographic organ or tissue transplant (organ or tissue transplants from a non-human donor) are not covered by the Indemnity Medical or Prescription Drug Plans.

30) Charges for medical services or supplies rendered or provided outside the United States, except for treatment for an Emergency Medical Condition (refer to the Glossary of Defined Terms).

31) Charges for claims received over one year from the date of service or more than one year from the date of the primary carriers Explanation of Benefits statement if this Plan is the secondary payer.

32) Habilitation Services. This exclusion does NOT apply to treatment of diagnosed mental health conditions consistent with generally recognized independent standards of current medical practice.

33) Gene therapy or services to treat any complications resulting from gene therapy

INDEMNITY PLAN CLAIMS AND APPEALS PROCEDURES

The procedures described in this section apply to the Indemnity Medical Plan, the Indemnity Dental Plan, prescription drugs and if you want to appeal an eligibility denial to the Board of Trustees.

If your Collective Bargaining Agreement provides for vision benefits and your vision claim is denied by Vision Service Plan (VSP), you must first exhaust the appeals procedures provided by VSP before appealing to the Board of Trustees.

What is Not a "Claim"

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

- A request made by **someone other than** the individual or their authorized representative;
- A request made by a **person who will not identify himself/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 of Plan benefits where prior approval is not required** by the Plan;
- An **eligibility inquiry that does not request Plan benefits**. However, if a benefit claim is denied on the grounds of lack of eligibility, it is treated as a denial and the individual will be notified of the decision and allowed to file an appeal;
- A **request for services and claims for a work-related injury/illness**, unless the Workers' Compensation program has provided a written confirmation that the injury/illness is not compensable as a work-related claim;
- A **submission of a prescription** with a subsequent denial at the point of sale at a retail pharmacy or from a mail order service. However, if your request for a prescription is denied, in whole or in part, you may file a claim and appeal regarding the denial by using the procedures outlined in this chapter.

Authorized Representatives

A Claimant may appoint in writing an Authorized Representative to act on their behalf in pursuing a claim or appeal under these claim procedures. A form for appointing an Authorized Representative is available from the Trust Office or the Claims Administration Office.

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

Eligibility Disputes and Appeals

If a claim for services is denied because you are not shown as eligible in the Trust Fund records or on the eligibility reports provided to Anthem Blue Cross, Kaiser, OptumRx, your pre-paid dental plan or Vision Service Plan, the Trust Fund staff will work with the provider of the services to resolve your eligibility status in accordance with the timeframes shown below, depending on the status of the claim.

Types of Claims and How to File Claims

Urgent Care Claims

Urgent Care Claims are defined as claims for medical care with respect to which a delay of up to 15 days in making decisions under the Pre-Service Claims procedures could:

- Severely jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function, or
- In the opinion of a Healthcare Practitioner with knowledge of the claimant's medical condition, would subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

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

Urgent Care Claims must be initially determined within 72 hours and appeals must be decided within 72 hours. Urgent Care medical claims must be filed with Anthem Blue Cross.

Anthem Blue Cross Utilization Management Department—Phone: (800) 274-7767

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

If your Healthcare Practitioner improperly files an Urgent Care Claim, Anthem Blue Cross will notify you and/or your Healthcare Practitioner as soon as possible but not later than 24 hours after receipt of the claim, of the proper procedures to be followed in filing a claim. Unless the claim is re-filed properly, it will not constitute a Claim.

Generally, Anthem Blue Cross will respond to you and your Healthcare Practitioner with a determination as soon as possible, taking into account the medical circumstances, but not later than 72 after receipt of the Claim.

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

Concurrent Care Decisions

Concurrent Care Decisions can occur when an ongoing course of treatment has been approved. Any decision to reduce the course of treatment must be given sufficiently in

advance to allow for an appeal. Concurrent Care appeals must be decided prior to termination of the benefit.

Concurrent Care hospital claims must be filed with the Anthem Blue Cross Utilization Management Department—Phone: (800) 274-7767.

Concurrent Care claims for other medical services will be made by either Anthem Blue Cross or the Claims Administration Office (in consultation with an independent review organization, if appropriate); whichever made the decision to terminate payment for the services.

A decision will be provided as soon as possible, but in any event early enough to allow you to have an appeal decided before the benefit is reduced or terminated.

Any request by a claimant to extend approved Urgent Care treatment will be acted upon by Anthem Blue Cross within 72 hours of receipt of the claim, provided the claim is received at least 24 hours prior to the expiration of the approved treatment.

Pre-Service Claims

Pre-Service Claims are claims for benefits, which must be approved by the Plan in advance of receiving the care in order to receive maximum benefits. The initial determination of such claims must be made within 15 days, and any appeal within 30 days.

Under the terms of this Plan, the following Medical Services should receive prior authorization in advance from Anthem Blue Cross Utilization Management Department—Phone: (800) 274-7767:

- Hospital admissions except for emergencies, childbirth, or when this plan is the secondary payor;
- Admission to a Skilled Nursing Facility;
- Home Health Care.

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

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

If an extension is needed because Anthem Blue Cross needs additional information from you, the extension notice will specify the information needed. In that case, you and/or your Healthcare Practitioner will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the period in which you are allowed to supply additional information, the normal period for making a decision on the claim will be suspended. The

deadline is suspended from the date of the extension notice until either 45 days or the date you respond to the request (whichever is earlier). Anthem Blue Cross then has 15 days to make a decision on a Pre-Service Claim and notify you of the determination.

Note: A determination on a Pre-Service Claim by Anthem Blue Cross is not a guarantee of benefits nor is it a claim payment determination.

Post-Service Claims

Post-Service Claims are requests for payments for services already provided, i.e. any claims that are not Urgent, Concurrent or Pre-Service claims. The initial determination is to be made within 30 days. A claim regarding rescission of coverage will be treated as a post-service claim.

The Claims Administration Office will notify you of any adverse benefit determination within a reasonable period of time, but not later than 30 days after receipt of the claim. If the Claim Administration Office determines that there is not sufficient information to determine the claim within the 30-day time limit, your claim will be denied and the Plan will notify you of the denial, state the reason for the denial, and specify the additional information needed. If you submit the necessary information within 45 days after receipt of the notification of the denial, there is no need to file a new claim. Once the Plan receives this information, it then has 15 days to make a decision on a Post-Service Claim and notify you of the determination.

Disability Claims

The term "Disability Claim" means a claim for which the plan must make a determination of disability in order for the participant to receive the benefit.

A Disability Claim must be submitted to the Trust Fund Office within 90 days after the date of the onset of the disability. To ensure that the persons involved with adjudicating disability claims and disability appeals (such as claim adjudicators and medical or vocational experts) act independently and impartially, decisions regarding hiring, compensation, promotion, termination or retention or other similar matters with respect to those individuals, will not be made based upon the likelihood that the individual will support the denial of benefits.

The Fund will make a decision on the Disability Claim and notify the Eligible Individual of the decision within 45 days after receipt of the Claim by the Trust Fund Office. If the Fund requires an extension of time due to matters beyond the control of the Plan, the Trust Fund Office will notify Eligible Individual of the reason for the delay and the date by which the Fund expects to render a decision. This notification will occur before the expiration of the initial 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

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

If an extension is needed because the Fund needs additional information from the Eligible Individual, the extension notice will specify the information needed. If the information is not provided within the 45-day period, the Claim will be denied. During the

45-day period in which the Eligible Individual is allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from the date of the notification; or (2) the date the Eligible Individual responds to the request. Once the Eligible Individual responds to the Plan's request for the information, the Eligible Individual will be notified of the Plan's decision on the Claim within 30 days.

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

Contents of Notifications

You will be provided with written notice of denial of a claim, whether denied in whole or in part. Notice will be sent by Anthem Blue Cross for all Urgent Care and Pre-Service Claims. Notice will be sent by the Claims Administration Office or Anthem Blue Cross for Concurrent Claims, depending on the type of service being received. Notice will be sent by the Claims Administration Office for all Post-Service Claims. The notice will state:

- The specific reason(s) for the determination, including:
- identify the claim involved (e.g., date of service, health care provider, claim amount if applicable, diagnosis and treatment codes and meanings of the codes);
- State that, upon request and free of charge, the diagnosis code and/or treatment code, and their corresponding meanings, will be provided. However, a request for this information will not be treated as a request for an internal appeal or an external review;
- Contain a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;
- Reference to the specific Plan provision(s) on which the determination is based;
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary;
- A description of the appeal procedures and applicable time limits;
- Provide an explanation of the Plan’s internal appeal procedure and external review process (when external review is relevant) along with time limits and information regarding how to initiate an appeal, including a description of the **expedited** appeal review process and external review process for urgent care claims (when external review is relevant);
- A statement of your right to file a request for an External review or, for an eligibility dispute, bring a civil action under ERISA Section 502(a) following an adverse benefit determination on review;
- If an internal rule, guideline, protocol or other similar criterion was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon written request at no charge;
- If the determination was based on the absence of medical necessity, or because the treatment was experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination,

applying the terms of the Plan to your claim, or a statement that it is available upon written request at no charge; and

- Disclose the availability of, and contact information for, any applicable ombudsman established under the Public Health Services Act to assist individuals with internal claims and appeals and external review processes (when external review is relevant).
- If you do not understand English and have questions about a claim denial, contact the Fund Office to find out if assistance is available.
    - SPANISH (Español): Para obtener asistencia en Español, llame al (877) 492-2778.
    - TAGALOG (Tagalog): Kung kailangan niyo ang tulong sa Tagalog tumawag sa (877) 492-2778.
    - CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 (877) 492-2778.
    - NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' (877) 492-2778.

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

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

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

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

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

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

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

E) If a Participant's address is in a county where ten percent or more of the population residing in the county is literate only in the same non-English language then the Plan shall include in the notice of initial benefit determination a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. The language services provided by the Plan shall include (i) oral language services (such as a telephone customer

assistance hotline) in any applicable non-English language and assistance with filing claims and appeals in any applicable non-English language; and (ii) upon request, a notice in any applicable non-English language.

How to Appeal an Adverse Decision on a Claim

Review Process

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

- Made in writing
- State the reason(s) for disputing the denial;
- Accompanied by any pertinent material not already furnished to the Plan; and
- Submitted within 180 days after you receive notice of denial.

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

You have the right to submit comments, documents, records, and other information in support of your claim for benefits for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. You will be provided, upon request and free of charge, reasonable access to and copies of, all documents, records and other information relevant to your Claim.

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

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

For Disability claims only: The claimant will be provided automatically and free of charge, with any new or additional evidence and/or additional rationale considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence/rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of appeal is required to be provided) to give claimant a reasonable opportunity to respond prior to that date. The Plan will extend the deadline for the final notice of appeal determination as may be necessary in order to provide a claimant a reasonable opportunity to respond to new or additional evidence and/or additional rationale pursuant to the timeframes for sending notices of appeal determinations as set forth below.

Where to File Appeals

Appeals involving an adverse determination on an Urgent Claim or a Concurrent Claim for Inpatient Services should be sent to Anthem Blue Cross. If your Urgent or Concurrent Care Claim appeal is denied by Anthem Blue Cross, the Trust Fund offers you the opportunity to voluntarily re-submit your appeal, under the Pre-Service Claim rules, directly to the Claims Administration Office to be re-reviewed by the appeals sub-committee of the Board of Trustees.

All Appeals involving an adverse determination of Pre-Service and Post Service Claims must be submitted to the Claims Administration Office for review by the Board of Trustees. Appeals must be submitted in writing to the Board of Trustees and must include the patient's name, participant's name, and a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees, the date of the Adverse Benefit Determination and the basis of the appeal.

Procedures for Filing a Claim Appeal with the Board of Trustees

Definitions

***Claimant*:** A participant or beneficiary under the Plan with a claim for benefits.

Disability Claim: A Disability Claim is a claim for which the Plan must make a determination of disability in order for the Participant to receive the benefit.

Pre-Service Claim: A pre-service claim is a request for benefits under this group health Plan where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care.

Urgent Care Claim*:* An urgent care claim is a claim (request) for medical care or treatment in which applying the time periods for preauthorization, as determined by your Healthcare Practitioner:

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

Concurrent Care Claim: A concurrent care claim refers to a Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment. A concurrent care claim also refers to a request by you to extend a pre-approved course of treatment. Individuals will be given the opportunity to argue in favor of uninterrupted continuity of care before treatment is cut short.

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

Rescission: Means a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to failure to timely pay required contributions. The Plan is permitted to rescind your coverage if you perform an act, practice or

omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of this Plan.

Independent Review Organization or IRO: Means an entity that conducts independent external reviews of Adverse Benefit Determinations in accordance with the Plan's external review provisions and current federal external review regulations.

***Named Fiduciary*:** The named fiduciary for determining appeals is the Board of Trustees or its Appeals Subcommittee. The Appeals Subcommittee consists of one Union Trustee and one Employer Trustee selected according to their availability with respect to a particular claim appeal. The Appeals Subcommittee can be contacted in the same manner as the Joint Board. The Appeals Subcommittee may meet by telephone conference call or other similar convenient method.

Timing of Claims Appeals Determinations

The Board of Trustees or the Appeals Subcommittee will take into account all comments, documents, records, and other information submitted by Claimant relating to the claim, without regard to whether such information was submitted or considered in the initial determination. They will not afford deference to the initial determination. If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not medically necessary, or was investigational or experimental), an independent health care professional, who has appropriate training and experience in a relevant field of medicine, will be consulted.

The appeals Subcommittee of the Board of Trustees will then review all relevant information and make a determination on your Pre-Service Claim Appeal within 30 days of receipt of the written appeal by the Fund Office.

Post-Service Claim and Disability Claim appeals will be reviewed by the Board of Trustees at their next regularly scheduled meeting. However, if the appeal is received within 30 days preceding the date of such meeting, the appeal may be decided by no later than the date of the second meeting following receipt of the appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your request for review may be necessary. You will be advised in writing in advance of this extension. The Claimant shall have no right to personally appear before the Board of Trustees unless it concludes, in its sole discretion, that such an appearance would be of value in enabling it to review the adverse initial determination.

The Claims Administration Office shall notify the Claimant of the decision of the Board of Trustees as soon as possible, but not later than 5 days after the appeal is decided

Notification of Appeals Decision

Adverse benefit determinations on appeal shall set forth, in a manner calculated to be understood by the Claimant, the following information:

- The specific reason or reasons for the decision.
- Reference to the specific Plan provisions on which the appeal is based.
- A statement that the Claimant is entitled to receive upon written request and free of charge reasonable access to and copies of all documents, records, and other information relevant to the Claimant's claim.

- If an internal rule, guideline, protocol or other similar criteria was relied upon in deciding the appeal, a statement that such document will be provided free of charge upon written request.
- If the appeal is based on a medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to the Claimant's medical circumstances will be provided free of charge upon written request.
- A statement of the Claimant's right to file a request for an External review or, for an eligibility dispute, bring a court action under ERISA §502(a).

The determination of a Disability appeal will include all of the above in addition to the following:

- A discussion of the decision, including the basis for disagreeing with or not following:
    - The view of a treating physician or vocational professional who evaluated the claimant;
    - The views of medical or vocational experts obtained by the plan, and
    - Any disability determination by the Social Security Administration.
- If the adverse benefit determination is based on medical necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the determination will be provided free of charge upon request;
- Any plan internal rules, guidelines, protocols, standards or other similar criteria that were used in denying the claim or a statement that such internal rules do not exist;
- A statement when the claim is denied that the claimant is entitled to receive relevant documents upon request; and to respond to new information by presenting written evidence and testimony.
- A statement describing any applicable contractual limitations period that applies to the claimant's right to bring an ERISA §502(a) action, including the calendar date on which the contractual limitations period for the claim expires.
- If a Participant's address is in a county where ten percent or more of the population residing in the county is literate only in the same non-English language, then the Plan shall include in the notice of appeal determination a statement prominently displayed in any applicable non-English language clearly indicating how to access the language services provided by the Plan. The language services provided by the Plan shall include (i) oral language services (such as a telephone customer assistance hotline) in any applicable non-English language and assistance with filing claims and appeals in any applicable non-English language; and (ii) upon request, a notice in any applicable non-English language.

External Review of Claims

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

If your appeal of a claim (whether pre-service, post-service or urgent care claim) is denied, you may request further review by an Independent Review Organization (IRO)

as described below. In the normal course, you may only request external review after you have exhausted the internal review and appeals process described above.

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

An Adverse Benefit Determination that is related to an Emergency Service, Non-Emergency Service provided by a Non-PPO Provider at a PPO facility, and/or Air Ambulances services, as covered under the No Surprises Act, may be eligible for External Review.

External Review of Standard Claims

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

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

Preliminary Review

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

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

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

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

Review By Independent Review Organization

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

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

- The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, such information must be submitted within ten (10) business days).
- Within five (5) business days after the assignment to the IRO, the Plan will provide the IRO with the documents and information it considered in making its Adverse Determination.
- If you submit additional information related to your claim, the assigned IRO must within one (1) business day forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, it will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.
- The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim *de novo* (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, any recommendations or other information from your treating health care providers, any other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).
- The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.
- The assigned IRO's decision notice will contain:
    - A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, and the treatment code and its corresponding meaning, and the reason for the previous denial);
    - The date that the IRO received the assignment to conduct the external review and the date of the IRO decision;

- References to the evidence or documentation, including the specific coverage provisions and evidence-based standards, considered in reaching its decision;
- A discussion of the principal reason(s) for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision;
- A statement that the determination is binding except to the extent that other remedies may be available to you or the Plan under applicable State or Federal law;
- A statement that judicial review may be available to you; and
- Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

Expedited External Review of Claims

You may request an expedited external review if:

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

Preliminary Review

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

After External Review

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

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

Legal Proceedings

Claimants may pursue their claims for benefits in court under ERISA §502(a) but only after they exhaust their administrative remedies as provided in these claims procedures. Failure of a Claimant to exhaust his or her administrative remedies will preclude further judicial review.

For disability appeals, administrative procedures will not be deemed to be exhausted if:

- The Plan's violation was de minimis and did not cause, and is not likely to cause, prejudice or harm to the Claimant so long as the Plan demonstrates that the violation was for good cause or due to matters beyond the control of the Plan and that the violation occurred in the context of an ongoing, good faith exchange of information with the Claimant;
- This exception is not available if the violation is part of a pattern or practice of violations;
- The Plan must provide a written explanation of the violation within 10 days of receipt of a request.

The Board of Trustees and its Appeals Subcommittee are given full discretionary authority (a) to finally determine all facts relevant to any claim, (b) to finally construe the terms of the Plan and all other documents relevant to the claim, and (c) to finally determine what benefits are payable from the Plan. Any decision made by the Board of Trustees or its Appeals Subcommittee shall be binding on all persons affected to the fullest extent permitted by law.

No decision of the Board of Trustees or its committees shall be revised, changed or modified by any arbitrator or court unless the party seeking such action is able to show by clear and convincing evidence that the decision of the Named Fiduciary for Appeals was an abuse of discretion in light of the information actually available to it at the time of its decision.

No lawsuit may be filed more than three years after the date proof of claim must be given to the Plan.

COORDINATION OF BENEFITS (COB)

Many families have more than one family member working and are covered by more than one health care plan. If this is the case with your family, you must let this Plan know about all coverages when you submit a claim.

Coordination of Benefits operates so that one of the plans (called the primary plan) will pay its benefits first. The other plan, (called the secondary plan) may then pay additional benefits. In no event will the combined benefits of the primary and secondary plans exceed 100% of the Covered Expenses incurred. Sometimes, the combined benefits that are paid will be less than total Covered Expenses.

No benefits are payable for claims submitted more than one year from the date the service was incurred.

If an Employee works for two different contributing employers who pay two separate contributions to the Trust Fund on his or her behalf, benefits will be payable for that individual consecutively as two Employees, up to the maximum amounts provided under the Plan. An Employee eligible as two Employees under this provision may also claim dual coverage benefits for his or her eligible Dependents. However in no event will the total amount of benefits payable under both claims exceed 100% of the actual eligible charges.

If an Employee is also eligible as a Dependent Spouse under the Plan, benefits will be payable as an Employee and as a Dependent consecutively, and each Employee may claim benefits on behalf of his or her Dependent children up to the maximum amounts provided under the Plan but in no event will the total amount of benefits payable exceed 100% of the actual eligible charges incurred. An individual covered as an Employee cannot also be covered as a Dependent Child.

If both the Employee and Spouse are Employees and their contributing employers pay two separate contributions to the Trust Fund, the Deductible for eligible Dental services will be waived.

If a Participant has (or is eligible for) Medicare coverage or some other government sponsored programs, such as Medicaid, TRICARE, or a program of the U.S. Department of Veterans Affairs, the coordination provisions are determined by federal or state law; however, to the extent that benefits are self-funded, state laws do not apply.

This Plan does not coordinate benefits with an individual plan. This means that when a plan participant is covered by this Plan and also covered by an individual (non-group) plan/policy, including a policy through the Health Insurance Marketplace, this Plan will not pay benefits toward the unpaid amount related to claims resulting from an individual plan/policy.

For all other benefits provided by this Plan, the order of benefit determination rules have been established by the National Association of Insurance Commissioners (NAIC) and are commonly used by insured and self-insured plans. Any group plan that does not use these same rules always pays its benefits first. If the first rule does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established. The rules are summarized below.

Which Plan Pays First – Order of Benefit Determination Rules

Rule 1: Employee / Dependent

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

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

Rule 2: Dependent Child Covered Under More Than One Plan

The plan that covers the parent whose birthday falls earlier in the calendar year pays first; and the plan that covers the parent whose birthday falls later in the calendar year pays second, unless the parents are separated or divorced. “Birthday” refers only to the month and day in a calendar year; not the year in which the person was born.

If the parents are not married or are separated (whether or not they ever were married), or are divorced, the terms of any applicable court decree will determine which parent is responsible for the child’s primary health care expenses. If there is no court decree allocating responsibility for the child’s health care services or expenses, the order of benefit determination among the plans of the parents and their spouses is:

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

For a dependent child covered under more than one plan of individuals who are not the parents of the child, the order of benefits shall be determined, as described in the longer/shorter length of coverage rule, and if length of coverage is the same, then the birthday rule applies. For example, if a married dependent child on this Plan is also covered as a dependent on the group plan of their spouse, this Plan looks to the longer/shorter rule first and if the two plans have the same length of coverage, then the Plan looks to whose birthday is earlier in the year: the employee-parent covering the dependent or the employee-spouse covering the dependent.

Rule 3: Active/Laid-Off or Retired Employee.

The plan that covers the person either as an active employee (that is, an employee who is neither laid-off nor retired), or as that active employee’s dependent, pays first; and the plan that covers the same person as a laid-off or retired employee, or as that laid-off or retired employee’s dependent, pays second. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Rule 4: Continuation Coverage.

If a person whose coverage is provided under a right of continuation under federal or state law is also covered under another plan, the plan that covers the person as an employee, retiree, member or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second. If the other plan does not have this rule, and if, as a result the plans do not agree on the order of benefits, this rule is ignored.

Rule 5: Longer/Shorter Length of Coverage

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

Rule 6: When no Rule Determines the Primary Plan.

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the expenses incurred by the covered person.

Benefit Reserve

This Plan does administer a benefit reserve for medical claims (not dental claims). This Plan will calculate its savings by subtracting the amount that it pays as the secondary plan from the amount that it would have paid had it been the primary plan. These savings will be recorded as a benefit reserve for the covered person for whom the claim is being determined and those savings in the benefit reserve will be used by the secondary plan to pay any allowable expenses not otherwise paid from all previous claims incurred by that covered person during the current claim determination period. At the end of the claim determination period, all unused amounts in the benefit reserve are canceled, and a new benefit reserve will be established with respect to claims incurred in the following claim determination period.

Coordination With Medicare

Typically, you become eligible for Medicare upon reaching age 65. Under certain circumstances, you may become eligible for Medicare before age 65 if you are a disabled worker or have 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 may be eligible to apply for both Parts A and B of Medicare. Since Part A of Medicare is ordinarily 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.

Active Employees

If you are an Active Employee, you may elect Medicare as your primary plan over this Plan; however, if you do so, you will cease to be eligible for medical benefits under this Trust Fund. If you are the Dependent of an Active Employee and you become eligible for Medicare, this Plan will pay benefits primary and Medicare may help with your out-of-pocket costs as secondary payer.

If you or your Dependent become eligible for Medicare due to End Stage Renal Disease (ESRD), this Plan will be the primary payer for the first 30 months starting the

earlier of the month in which Medicare ESRD coverage begins or the first month in which the individual receives a kidney transplant. Contact the Fund Office for additional information.

Retirees

When you retire and are no longer eligible for benefits as an Active Employee, or if you are the Dependent Spouse of such a Retiree, when you become eligible for Medicare due to age or disability, **you must enroll in both Part A and Part B of Medicare**. Your claims will be paid first by Medicare. Once you received an Explanation of Medicare Benefits, you should submit the claim to this Plan, which will pay the remaining charges allowed by Medicare but not paid by Medicare. The Plan will also cover otherwise covered services that are Medically Necessary services if those services are not covered by Medicare.

If you do not enroll in both Part A and Part B of Medicare, the Plan will pay benefits **as if** Medicare had paid primary benefits. You will be responsible for your normal out-of-pocket costs plus all amounts that Medicare would have paid. This same rule applies if you enter into a "Private Contract" with a Healthcare Practitioner, in which you agree that the Healthcare Practitioner does not submit any of their charges to Medicare and you are responsible for all billed charges.

IMPORTANT NOTE FOR MEDICARE-ELIGIBLE RETIREES

Your coverage under the California Service Employees Health and Welfare Trust Fund may continue when you retire. However, if you are age 65 or over, Medicare will become the primary payer for your covered medical expenses and this Plan will pay benefits after Medicare pays its portion of the bill.

Benefits that are paid for by this Plan for Medicare-eligible individuals are reduced by the amounts payable under Medicare Parts A (Hospital), and B (Professional services). This reduction will apply even if the Medicare-eligible individual is NOT enrolled in Medicare Part A and B; therefore, **if you are a Medicare-eligible Retiree, you should consider enrolling in Medicare Part A and B, in order to receive the maximum amount of benefits to which you are entitled under this Plan.**

Information Gathering

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

Facility of Payment

If the Plan Administrator 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 Provider(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, claim administrator nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

SUBROGATION AND REIMBURSEMENT

If a Participant is injured through the act or omission of another party, benefits are provided only on certain conditions. A Participant is required to promptly reimburse the Plan from any and all proceeds recovered collectively from all sources, including but not limited to proceeds designated as being punitive damages or for pain and suffering, received by way of settlement, verdict, judgment or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance) arising out of any claims for money or other damages by the Participant or her or his heirs, parents or legal guardians, to the extent of benefits paid or to be paid by the Plan for which the third party may be responsible.

Any Participant who accepts Plan benefits agrees that by doing so she or he is making a present assignment of his rights against a third party to the extent of the payments made by the Plan (and any attorney fees and costs incurred by the Plan). These rules are automatic, but the Plan will require that a Participant sign an agreement to reimburse or assignment of recovery form(s). Any Participant who refuses to sign an agreement or assignment shall not be eligible for Plan benefit payments related to the injury involved. Any Participant who receives benefits and later fails to reimburse the Plan will be ineligible for future Plan benefits until the Plan has withheld an amount equal to the amount, which the Participant failed to reimburse. This amount may also include reasonable interest on such unpaid funds and reimbursement for any attorney fees and costs incurred by the Plan.

By accepting benefits provided by the Plan, a Participant agrees that:

- The Plan has the right to intervene, independently of the Participant, in any legal action brought against the third party or any insurance company, including the Participant's own carrier for uninsured motorist coverage.
- An equitable lien by agreement shall exist in favor of the Plan upon all funds recovered by the Participant against the third party. The lien shall apply whether or not the recovery is in the possession of the participant, including situations in which the recovery has been placed in a special needs trust. The lien may, but is not required to, be filed with the third party, the third party's agent, or the court. The Participant, and those acting on his or her behalf, shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent. The Participant agrees to waive any defense based upon an inability of the Plan to trace amounts recovered and agrees that the lien may be satisfied by any assets of the Participant. A constructive trust also shall exist over all funds recovered by the participant, at the election of the Plan. The Participant shall provide the Plan with all relevant information or documents requested.
- The Plan's Subrogation and Reimbursement rights shall be considered as a first priority claim against another person or entity, to be reimbursed before any other claims (including claims for general damages).
- The Participant will not release any party from liability for payment of medical expenses without first obtaining written consent from the Plan.
- If the Participant enters into litigation or settlement negotiations regarding obligations of or claims against another party, the Participant will notify the Plan and shall take no action to prejudice the Plan's rights.

- If the Participant settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in the third party or its insurance carrier being relieved of any future liability for medical costs, then the Participant shall receive no further benefits from the Plan in connection with the medical condition forming the basis of the third party liability claim unless the Plan or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Plan.

The Participant agrees that the Plan shall be responsible only for those legal fees and expenses to which the Plan agrees in writing. Unless the Plan agrees otherwise, the rights of the Plan to recover the amount of benefits issued shall in no way be diminished by the cost of a Participant's legal representation.

The Participant agrees to hold proceeds of any settlement, verdict, judgment, or other recovery in trust for the benefit of the Plan, and that the Plan shall be entitled to recover reasonable attorney fees incurred in collecting reimbursement of benefits issued.

In addition to all other remedies that the Plan may have, the Plan shall be subrogated to the rights of the Participant or his beneficiary against the responsible third party or its insurer.

Any "make whole" rule of federal or state law is expressly rejected and shall not be applicable to the Trust Fund, so that a participant need not be made whole before the Trust Fund can enforce its right of reimbursement.

HIPAA: USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

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

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

A complete description of your rights under HIPAA can be found in the Plan's Notice of Privacy Practices, which was previously distributed to you and is also available from the Fund Office. Information about HIPAA in this document is not intended and cannot be construed as the Plan's Notice of Privacy Practices.

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

A. **The Plan's Use and Disclosure of PHI:** The Plan will use PHI, without your authorization or consent, to the extent and in accordance with the uses and disclosures permitted by the privacy regulations under HIPAA. Specifically, the Plan will use and disclose protected health information for purposes related to health care treatment, payment for health care, and health care operations (sometimes referred to as TPO), as defined below.
    1. **Treatment** is the provision, coordination or management of health care and related services. It also includes but is not limited to coordination of benefits with a third party and consultations and referrals between one or more of your health care providers.
    2. **Payment** includes activities undertaken by the Plan to obtain premiums or determine or fulfill its responsibility for coverage and provision of Plan benefits with activities that include, but are not limited to, the following:
        a. Determination of eligibility, coverage, cost sharing amounts (e.g. cost of a benefit, Plan maximums, and copays as determined for an individual's claim), and establishing employee contributions for coverage;
        b. Claims management and related health care data processing, adjudication of health benefit claims (including appeals and other payment disputes),

coordination of benefits, subrogation of health benefit claims, billing, collection activities and related health care data processing, and claims auditing;

c. Medical necessity reviews, reviews of appropriateness of care or justification of charges, utilization management, including preauthorization, concurrent review and/or retrospective review.

3. **Health Care Operations** include, but are not limited to:

a. Business planning and development, such as conducting cost-management and planning-related analyses for the management of the Plan, development or improvement of methods of payment or coverage policies and quality assessment,

b. Population-based activities relating to improving health or reducing health care costs, protocol development, case management and care coordination, disease management, contacting of health care providers and patients with information about treatment alternatives and related functions,

c. Underwriting, premium rating, and other activities relating to the renewal or replacement of a contract of health insurance or health benefits, rating provider and Plan performance, including accreditation, certification, licensing, or credentialing activities. (**Note**, the Plan will not use or disclose PHI that is genetic information for underwriting purposes.)

d. Conducting or arranging for medical review, legal services and auditing functions, including fraud and abuse detection and compliance programs, and enforcement of liens and other claims,

e. Business management and general administrative activities of the Plan, including, but not limited to management activities relating to implementation of and compliance with the requirements of HIPAA Administrative Simplification, customer service, resolution of internal grievances, or the provision of data analyses for policyholders, Plan sponsors, or other customers.

f. Compliance with and preparation of documents required by the Employee Retirement Income Security Act of 1974 (ERISA), including Form 5500's, Summary Annual Reports and other documents.

B. **When an Authorization Form is Needed:** Generally, the Plan will require that you sign a valid authorization form (available from the Fund Office) in order for the Plan to use or disclose your PHI **other than** when you request your own PHI, a government agency requires it, or the Plan uses it for treatment, payment or health care operations. The Plan's Notice of Privacy Practices also discusses times when you will be given the opportunity to agree or disagree before the Plan uses and discloses your PHI.

C. **The Plan will disclose PHI to the Plan Sponsor only** upon receipt of a certification from the Plan Sponsor that the Plan documents have been amended to incorporate the following provisions. With respect to PHI, the Plan Sponsor agrees to:

1. Not use or disclose the information other than as permitted or required by the Plan Document or as required by law,

2. Ensure that any agents, including subcontractors, to whom the Plan Sponsor provides PHI received from the Plan agree to the same restrictions and conditions that apply to the Plan Sponsor with respect to such information. This

Plan hires professionals and other companies, referred to as Business Associates, to assist in the administration of benefits. The Plan requires these Business Associates to observe HIPAA's Privacy Rule. Effective September 23, 2009, the HITECH Act from the American Recovery and Reinvestment Act (ARRA) requires Covered Entities and Business Associates to directly comply with certain increased safeguards for individuals' PHI.

3. Not use or disclose the information for employment-related actions and decisions.
4. Not use or disclose PHI for marketing purposes or sale without your written authorization.
5. Not use or disclose the information in connection with any other benefit or employee benefit Plan of the Plan Sponsor, (unless authorized by the individual or disclosed in the Plan's Notice of Privacy Practices).
6. Report to the Plan any use or disclosure of the information that is inconsistent with the uses or disclosures provided for of which it becomes aware,
7. Make PHI available to the individual in accordance with the access requirements of HIPAA,
8. Make PHI available for amendment and incorporate any amendments to PHI in accordance with HIPAA,
9. Make available the information required to provide an accounting of PHI disclosures,
10. Make internal practices, books, and records relating to the use and disclosure of PHI received from the group health Plan available to the Secretary of the Department. of Health and Human Services (HHS) for the purposes of determining the Plan's compliance with HIPAA, and
11. If feasible, return or destroy all PHI received from the Plan that the Plan Sponsor maintains in any form and retain no copies of such information when no longer needed for the purpose for which disclosure was made. If return or destruction is not feasible, limit further uses and disclosures to those purposes that make the return or destruction of the PHI infeasible.

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

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

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

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

RIGHTS OF THE BOARD OF TRUSTEES

Authority to Make Changes

The Board of Trustees of the California Service Employees Health and Welfare Trust Fund 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 amendment, modification, revocation, or termination of the Plan is 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. The provisions of the Plan are subject to and controlled by provisions of the Trust Agreement, and in the event of any conflict between provisions of the Plan and provisions of the Trust Agreement, provisions of the Trust Agreement shall prevail.

Right to Recover Excess Payments

If a benefit payment has been made by this Plan which exceeds the amount that should have been paid under the Plan, the Plan has the right to recover (including the right to offset against future benefit payments) overpaid 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 overpaid amounts to be paid. No Participant shall be required to pay more than the amount actually overpaid. In the event the Plan brings legal action to recover any overpayment, the Plan is entitled to recover its costs and attorney's fees incurred in such action. (Refer also to Subrogation page 119).

Discretionary Authority for Plan Interpretation, Administration and Operation

The Board of Trustees of the Plan is the named fiduciary with the authority to control and manage the operation and administration of the Plan. The Board shall make such rules, interpretations, and computations, factual findings, and take such other actions to administer the Plan 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 Plan, benefits payable, and any rules adopted by the Board of Trustees.

The Plan recognizes that new technologies may develop which are not specifically addressed. The Plan reserves the right to determine whether or not a service or supply is covered, and if covered, to determine the Allowed Charge. If a Participant selects a more expensive service or supply than is customarily provided, or specialized techniques rather than standard procedures, the Plan 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 Plan, as it shall determine to be necessary and appropriate.

Non-Assignment

Coverage and your rights under this Plan may not be assigned. Benefits payable shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person without the express written permission of the Plan Sponsor; however, a Plan Participant may direct that benefits due to them be paid to a Health Care Provider in consideration for hospital, medical, dental and/or vision care services rendered, or to be rendered. The Plan, in its discretion, may make such payment to the Health Care Provider as directed by the Plan Participant. A direction to pay a provider is not an assignment of any right under this Plan or under ERISA, is not authority to act on a Participant's behalf in pursuing and appealing a benefit determination under the Plan, is not an assignment of rights respecting anyone's fiduciary duty, and is not an assignment of any legal or equitable right to institute any court proceeding.

NAMES AND ADDRESSES OF PROVIDERS TO THE PLAN

Kaiser Foundation Health Plan Northern California Region 1950 Franklin Street Oakland, CA 94612 (800) 464-4000 *Provides prepaid insured medical benefits and prescription drug benefits to participants who elect*	**Kaiser Foundation Health Plan** Southern California Region Walnut Center Pasadena, CA 91188-8516 (800) 464-4000 *Provides prepaid insured medical benefits and prescription drug benefits to participants who elect*

the Kaiser option, with guaranteed payment of these benefits.	*the Kaiser option, with guaranteed payment of these benefits.*
Anthem Blue Cross Prudent Buyer Anthem Blue Cross Prudent Buyer P.O. Box 60007 Los Angeles, CA 90060-0007 *Is the contracted PPO network, provides Utilization Management and Case Management for eligible participants in the indemnity medical plan. Benefits are self-funded*.	**OptumRx** *Administers the prescription drug program for eligible participants in the indemnity medical plan, does not guarantee payment of prescription drug benefits*.
Delta Dental Plan 12898 Towne Center Dr. Cerritos, LA 90703 (562) 403-4040 *Provides prepaid dental benefits to enrolled participants, with guaranteed payment of these benefits.*	**Vision Service Plan** 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195 *Administers vision plan for participants eligible for vision benefits; does not guarantee payment of vision benefits.*
ReliaStar Life Insurance Company P.O. Box 20 Minneapolis, Minnesota 55440 Telephone Number: (800) 955-7736 *Insures Life and AD&D for eligible participants*.	

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

The Name of the Plan is:

California Service Employees Health and Welfare Trust Fund

The Name, Address and Zip Code of the Plan Sponsor (Plan Administrator) is:

The Plan is an Employee Welfare Benefits Plan administered and maintained by the Joint Board of Trustees.

Board of Trustees - California Service Employees Health and Welfare Trust Fund
2323 Eastlake Ave East
Seattle, WA 98102

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

Internal Revenue Service Employee Identification Number (EIN):

The Employer Identification Number (EIN) is 94-1206350.

Plan Number:

The Plan number is 501.

Plan Year:

The Plan's fiscal year ends on: April 30

The Contract Administrator for Processing Indemnity Medical and Dental Claims is:

Northwest Administrators
2323 Eastlake Ave East
Seattle, WA 98102 (844) 492-9158

If you are in Kaiser or a Pre-Paid Dental Plan, or you receive vision benefits from a non-VSP provider, you should refer to your ***Evidence of Coverage*** for claim filing instructions.

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

Blair Fowler
Northwest Administrators
2323 Eastlake Ave East
Seattle, WA 98102

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

Source of Financing

The cost of the Plan is paid by the employer contributions to the Trust Fund. This Welfare Plan is maintained pursuant to various Collective Bargaining Agreements with Locals affiliated with the Service Employees International Union – CTW. Copies of the

Collective Bargaining Agreements are available for inspection at the Fund Office during regular business hours, and upon written request, will be furnished by mail. A copy of any Collective Bargaining Agreement which provides for contributions to the Fund will also be available for inspection within ten (10) calendar days after written request at the Union office or at any office of any Contributing Employer to which at least 50 Plan participants report each day.

The benefits provided by this Plan, while intended to remain in effect indefinitely, can be guaranteed only so long as the parties to the ***Collective Bargaining Agreements*** continue to require contributions into the Plan sufficient to underwrite the cost of the benefits. Should contributions cease and the reserves be expended, the Trustees would no longer be obligated to furnish coverage. These are not vested or guaranteed lifetime benefits.

Participants and beneficiaries may receive from the Plan Administrator, upon written request, information as to whether a particular employer or employee organization is a sponsor of the plan and, if the employer or employee organization is a plan sponsor, the sponsor's address.

Names and addresses of Trustees:

Employer Trustees

Larry Smith
2323 Eastlake Ave East
Seattle WA 98102

Christopher B. Bouvier
ABM Industries, Inc.
1776 Yorktown St Ste. 800
Houston, TX 77056

Raymond Nann (Alternate)
2323 Eastlake Ave East
Seattle WA 98102

Jim Altieri (Alternate)
2323 Eastlake Ave East
Seattle WA 98102

Union Trustees

Mark Sharwood, Chairman
SEIU United Service Workers West
1401 21st Street, Suite 310
Sacramento, CA 98511

David Huerta
SEIU United Service Workers West
828 W. Washington Blvd.
Los Angeles, CA 90015

Luis Fuentes (Alternate)
SEIU United Service Workers West
828 W. Washington Blvd.
Los Angeles, CA 90015

Eligibility Provisions

The Plan's requirements with respect to eligibility for benefits are briefly outlined in the ***Eligibility Rules*** section of this ***Summary Plan Description***. You should refer to the ***Collective Bargaining Agreement*** with your Signatory Employer for the specific requirements for you to be eligible for benefits.

Procedures to be followed in presenting claims for benefits under the Plan:

Claim filing procedures for the Indemnity Medical Plan and the Indemnity Dental Plan are described in the ***Indemnity Plan Claims and Appeals Procedures*** section of this Summary Plan Description.

Remedies are available under the Plan for the redress (appeal) of claims, which are denied in whole or in part, including provisions required by Section 502 of the ***Employee Retirement Income Security Act.*** The remedies are described in the section of this booklet entitled ***Claims and Appeals Procedures.***

Be sure to state your Social Security Number when communicating with the Fund Office on any matter concerning your benefits. Send all inquiries and claims to the address in the Quick Reference Chart at the beginning of this SPD.

Statement of Rights under Employee Retirement Income Security Act of 1974

As a Participant in the California Service Employees Health & Welfare Trust Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA) and subsequent amendments. ERISA provides that all Plan Participants are entitled to:

- Examine, without charge, at the Plan's Fund Office and at other specified locations such as worksites and union halls, all Plan documents, including insurance contracts, Collective Bargaining Agreements, and copies of all documents filed by the Plan with the U.S. Department of Labor, such as detailed annual reports and Plan descriptions.
- Obtain copies of all Plan documents and other Plan information upon written request to the Plan Administrator. 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 health care coverage for yourself and Dependent(s) if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your Dependent(s) may have to pay for such coverage. Refer to the COBRA Continuation Coverage section of this booklet.
- Reduction or elimination of exclusionary periods of coverage for pre-existing conditions under your Plan if you have creditable coverage from another plan. You should be provided a certificate of creditable coverage, free of charge, from your Plan 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 pre-existing condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

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 your interest and the interest of 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. If your claim for a welfare benefit is denied in whole or in part, you must receive a written explanation of the reason for denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request certain materials required to be furnished by the Plan and do not receive them within 30 days, you may file suit in a federal court. In such 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 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; for example, if it finds your claim frivolous.

If you have questions about your Plan, you should contact the Plan Administrator. If you have questions about this statement or about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210.

GLOSSARY OF DEFINED TERMS

The following are definitions of specific terms used in this document that are intended to help you understand covered or excluded health care services under the Indemnity Medical and Prescription Drug Plans. These definitions do not, and should not be interpreted to extend coverage under the Plans.

"Affordable Care Act (ACA)" means comprehensive federal health care reform law enacted in March 2010 (sometimes known as ACA, PPACA, Health Reform, or "Obamacare"). The law has 2 parts: the Patient Protection and Affordable Care Act (PPACA) and the Health Care and Education Reconciliation Act (the Reconciliation Act).

"Air Ambulance" means medical transport for patients by a rotary wing air ambulance or fixed wing air ambulance as defined in 42 CFR § 414.605.

"**Allied Health Care Practitioner**" means a licensed physical, occupational, or speech therapist, a Naturopathic Physician (N.D.), a Homeopathic, a Dentist (D.D.S.), licensed Podiatrist (D.P.M.), Chiropractor (D.C.), Psychologist, Physician Assistant, Nurse Midwife, Nurse Practitioner or Certified Acupuncturist who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered. The term shall not include any person who is the spouse, child, brother, sister, or parent of the Active or Retired Employee unless such person is acting within the scope of professional licensure issued under state law.

"Allowed Charge/Allowed Amount/Allowable Charge/Maximum Allowable Fee" means the amount this Plan allows as payment for eligible Medically Necessary services or supplies. The Allowed Charge amount is determined by the Plan Administrator or its designee to be the **lowest** of:

1. **With respect to a PPO provider**, the negotiated fee/rate set forth in the agreement between the participating network health care provider/facility and the network or the Plan; **or**
2. **With respect to a Non-PPO provider**, Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-PPO providers.

   The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim. **or**
3. For a PPO provider/facility whose network contract stipulates that they do not have to accept the network negotiated fee/rate for claims involving a third party payer, including but not limited to auto insurance, workers' compensation or other individual insurance, or where this Plan may be a secondary payer, the Allowed Charge amount under this Plan is the negotiated fee/rate that would have been payable by the Plan had the claim been processed as a PPO claim; **or**
4. The health care provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the health care provider's actual charge for health care services or supplies, even after you have paid any applicable

Deductible, Copay and/or Coinsurance. This is because the Plan covers only the "Allowed Charge" amount for health care services or supplies.

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

Additionally, the Plan reserves the right to negotiate with a Non-PPO provider to reduce their billed charges to a lower, discounted Allowed Charge amount. Such negotiation may be performed by the Plan Administrator or its designee. A designee may include, but is not limited to, a Utilization Management Company, Claims Administrator, Fund Office, attorney, medical claim repricing firm or a discount negotiation firm. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the Non-PPO provider considering the plan's cost-sharing provisions, PPO/Non-PPO plan design, and any special reimbursement provisions adopted by the Plan.

In accordance with federal law, with respect to Emergency Services performed in a Non-Contracted Emergency Room (ER), the Plan's allowance for ER visit facility fees is to pay the **greater** of:

a) the negotiated amount for In-Network providers (the median amount if more than 1 amount to In-Network providers), or

b) 100% of the Plan's usual payment (Allowed Charge) formula (reduced for cost-sharing) or

c) (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing).

NOTE: These minimum payment standards for Emergency Services in a hospital emergency room **do not apply** in cases where state law prohibits a person from being required to pay balance-billed charges or where the Plan is contractually responsible for such charges.

"Ancillary Services" are, with respect to a PPO Health Care Facility:

- Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,
- Items and services provided by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and
- Items and services provided by a Non-PPO Provider if there is no PPO Provider who can furnish such item or service at such facility.

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

"Cost Sharing/Cost Sharing Amount/Cost-Sharing Requirement" means the amount a participant or beneficiary is responsible for paying for a covered item or service under the terms of the plan. Cost Sharing generally includes copayments, coinsurance, and amounts paid towards deductibles, but does not include amounts paid towards premiums, balance

billing by Non-PPO Providers, or the cost of items or services that are not covered under the Plan.

The "**Cost Sharing Amount"** for Emergency and Non-Emergency Services at PPO Facilities performed by Non-PPO Providers, and Air Ambulance services from Non-PPO Providers will be based on the Recognized Amount.

"Continuing Care Patient" means an individual who, with respect to a provider or facility-

1. Is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;
2. Is undergoing a course of institutional or inpatient care from the provider or facility;
3. Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such a surgery;
4. Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or
5. Is or was determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

"**Covered Expenses**" means Allowed Charges incurred by a Participant while coverage is in force which are:

- For care and treatment of an Illness or Injury as defined in the Plan; and
- Medically Necessary; and
- For covered services under the provisions of the Plan, and which are not expressly excluded.

"**Custodial Care**" means services provided mainly for personal hygiene or to perform the activities of daily living. Some examples of custodial care are helping patients get in and out of bed, bathe, dress, eat, use the toilet, walk, or take drugs or medicines that can normally be self-administered. These services are custodial care regardless of where the care is given or who recommends, provides, or directs the care. Custodial care can be given safely and adequately (in terms of generally accepted medical standards) by people who are not trained or licensed medical or nursing personnel. Custodial care may be payable by this plan only under certain limited circumstances such as when custodial care is provided during a covered hospitalization or during a covered period of hospice care.

"**Domestic Partner**" means a person of the same or opposite sex as the Employee or Retiree who meets all of the following requirements:

- The individuals are each other's sole "Domestic Partners" and have been such for at least six consecutive months prior to the signing of a notarized Affidavit of Domestic Partnership provided by the Fund Office. **A registered Declaration of Domestic Partnership filed with the Secretary of State of California may also be submitted**.
- Domestic Partner means the individuals reside together in the same residence, are jointly responsible for each other's common welfare and financial obligations and can submit proof of such relationship as may be required by the Trustees, including:
    - Neither individual is married;
    - The individuals are 18 years or older;

- The individuals are competent to contract;
- The individuals are not related by blood closer then would prohibit legal marriage in the state of California;
- Any prior Domestic Partnership of either individual has been terminated not less than six months prior to the date of the signing of the Declaration; and
- The employee pays the income taxes on the value of the Domestic Partner benefits as required by law.

The Trustees reserve the right to require evidence of the existence of the Domestic Partnership, at their sole discretion.

"**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.

"Emergency Services" means with respect to an Emergency Medical Condition (defined below), a medical screening examination **within the emergency department of a hospital** including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient. The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary 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 individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta).

"Emergency Medical Condition" means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the health of a woman or her unborn child in serious jeopardy.

"Emergency Services" means the following:

1. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an Independent Freestanding Emergency Department, as applicable, including Ancillary Services routinely available to the emergency department to evaluate such Emergency Medical Condition; and
2. Within the capabilities of the staff and facilities available at the hospital or the Independent Freestanding Emergency Department, as applicable, such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

Emergency Services furnished by a Non-PPO Provider or Non-PPO Emergency Facility (regardless of the department of the hospital in which such items or services are furnished) also include post stabilization services (i.e., items and services provided after the patient is

stabilized) and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which the Emergency Services were furnished, until:

- The attending emergency physician or treating provider determines that the participant or beneficiary is able to travel a reasonable distance using nonmedical transportation or nonemergency medical transportation; and

The participant or beneficiary is supplied with a written notice, as required by federal law, that the provider is a Non-PPO Provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO Providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO Providers listed; and The participant or beneficiary gives informed consent to continued treatment by the Non-PPO Provider, acknowledging that the participant or beneficiary understands that continued treatment by the Non-PPO Provider may result in greater cost to the participant or beneficiary.

"**Employee**" means each Active Employee who meets the eligibility rules set forth in the ***Collective Bargaining Agreement*** with the Local Union under which the Employee works. Employee shall also include employees of the Local Unions on behalf of whom contributions are made to the Trust Fund in accordance with a Subscription Agreement approved by the Board of Trustees. The ***Eligibility Rules*** section of this booklet provides the terms of coverage for Retirees and Dependents.

"**Employer**" means any proprietor, partnership, corporation, or entity which employs Employees and is a party to a Labor Agreement with the Union. The term "Employer" may include the Union if the inclusion of the Union does not jeopardize the tax-exempt status of the Fund.

"Experimental and/or Investigational" Services. A service or supply will be deemed to be Experimental and/or Investigational if, in the opinion of the Plan Administrator or its designee, based on the information and resources available at the time the service was performed or the supply was provided, or the service or supply was considered for Preauthorization under the Plan's Utilization Management program, any of the following conditions were present with respect to one or more essential provisions of the service or supply:

- The service or supply is described as an alternative to more conventional therapies in the protocols (the plan for the course of medical treatment that is under investigation) or consent document (the consent form signed by or on behalf of the patient) of the Health Care Provider that performs the service or prescribes the supply.
- The prescribed service or supply may be given only with the approval of an Institutional Review Board as defined by federal law.
- In the opinion of the Plan Administrator or its designee, there is either an absence of authoritative medical or scientific literature on the subject, or a preponderance of such literature published in the United States, and written by experts in the field; shows that recognized medical or scientific experts classify the service or supply as experimental and/or investigational or indicate that more research is required before the service or supply could be classified as equally or more effective than conventional therapies.
- With respect to services or supplies regulated by the Food and Drug Administration (FDA), FDA approval is required in order for the service and supply to be lawfully marketed and it has not been granted at the time the service or supply is prescribed or provided; or a current investigational new drug or new device application has been submitted and filed with the FDA. The prescribed service or supply is available to the

covered person only through participation in Phase I or Phase II clinical trials; or Phase III experimental or research clinical trials or corresponding trials sponsored by the FDA, the National Cancer Institute, or the National Institutes of Health.

Note that under this medical plan, experimental, investigational or unproven does not include **routine costs associated with a certain "approved clinical trial" related to cancer or other life-threatening illnesses.** The routine costs that are covered by this Plan are discussed below:

A) "**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.

B) An "**approved clinical trial**" means a phase I, II, III, or IV clinical trial [including a clinical trial titled as a pilot study] conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial [including a clinical trial titled as a pilot study] or investigation must be (1) federally funded; (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. "Federally funded" clinical trials include those approved or funded by one or more of: the National Institutes of Health (NIH), the Centers for Disease Control & Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS), a cooperative group or center of the NIH, CDC, AHCRQ, CMS, the Department of Defense (DOD), the Department of Veterans Affairs (VA); a qualified non-governmental research entity identified by NIH guidelines for grants; or 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.

C) A participant or beneficiary covered under a group health plan is eligible to participate in a clinical trial and receive benefits from a group health plan for routine services if: (1) the individual satisfies the eligibility requirements of the protocol of an approved clinical trial; and (2) either the individual's referring physician is a participating health care provider in the plan who has determined that the individual's participation in the approved clinical trial is medically appropriate, or the individual provides the plan with medical and scientific information establishing that participation in the trial would be medically appropriate.

D) The plan may require that an eligible individual use an in-network provider as long as the provider will accept the patient. This plan is only required to cover out-of-network costs for routine clinical trial expenses if the clinical trial is only offered outside the patient's state of residence.

The plan may rely on its Utilization Management Company or other medical review firm to determine, during a review process, if the clinical trial is related to cancer or a life-threatening condition, as well as to help determine if a person's routine costs are associated with an "approved clinical trial." During the review process, the person or their attending

Physician may be asked to present medical and scientific information that establishes the appropriateness and eligibility for the clinical trial for their condition. The Plan (at no cost to the patient) reserves the right to have the opinion of a medical review firm regarding the information collected during the review process. See the INDEMNITY PLAN CLAIMS AND APPEALS PROCEDURES chapter for information on the appeal process of the Plan. Additionally, external review is available for an adverse determination related to coverage of routine costs in a clinical trial.

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

Medical records of the covered person;

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

"**Fund**" means the California Service Employees Health and Welfare Trust Fund.

"Health Care Facility" (for non-Emergency Services) is each of the following:

1. A hospital (as defined in section 1861(e) of the Social Security Act);
2. A hospital outpatient department;
3. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and
4. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act

"Health Care Practitioner" means Acupuncturist, certified registered nurse anesthetist (CRNA), Chiropractor, Dental Hygienist, Dentist, Nurse (RN, LVN, LPN), Nurse Practitioner, Certified Nurse Midwife, Physician Assistant (PA), or Occupational, Physical, Respiratory or Speech Therapist or Speech Pathologist, Master's prepared Audiologist, Optometrist, Optician for vision plan benefits, Registered Dietitian Certified Diabetes Educator, or Pharmacist, who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered: and acts within the scope of his or her license and/or scope of practice. See also the definition of Physician. To the extent required by ACA regulations, a Health Care Practitioner includes a health care provider acting within the scope of the provider's license or certification under applicable State laws, and is performing a covered service under this Plan.

"Hospital" means a class of health care institutions that is a public or private facility or institution, licensed and operating as a hospital in accordance with the laws of the appropriate legally authorized agency, which:

- Provides care and treatment by Physicians and Nurses on a 24-hour basis for illness or injury through the medical, surgical and diagnostic facilities on its premises; and
- Provides diagnosis and treatment on an inpatient basis for compensation; and
- Is approved by Medicare as a Hospital.

The facility may also be accredited as a hospital by The Joint Commission (TJC). A hospital may include facilities for mental health and substance abuse treatment that are licensed and operated according to law.

Any portion of a Hospital used as an Ambulatory Surgical/Outpatient Surgery Facility, Birth (or Birthing) Center, Hospice, Skilled Nursing Facility, Inpatient Rehabilitation facility, Subacute Care Facility/Long Term Acute Care facility or place for rest, Custodial Care, or facility for the aged will **not** be regarded as a Hospital for any purpose related to this Plan.

"**Illness**" means a bodily disorder, infection, or disease and all related symptoms and recurrent conditions resulting from the same cause. An Illness identified in the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM) is considered to be a mental health disorder for the purposes of this Plan. If there are multiple diagnoses, only the treatment for the Illness identified under the DSM code is considered mental health treatment. Illness does not include a condition incurred or aggravated while performing a job-related task, engaging in any activity for wage or profit, or for which compensation could be available if application were made under a workers' compensation or occupational injury law or similar legislation. **Pregnancy of a covered Employee or covered Spouse will be considered to be an Illness only for the purpose of coverage under this Plan.** However, **infertility is not an Illness** for the purpose of coverage under this Plan. Prenatal and postnatal visits for a pregnant dependent child will be an illness that is covered by this Plan, but not ultrasounds and other pregnancy-related services of the pregnant dependent child, the delivery and/or newborn expenses.

"Independent Freestanding Emergency Department" is a health-care facility (not limited to those described in the definition of Health Care Facility) that is geographically separate and distinct from a hospital under applicable State law and provides Emergency Services.

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

"**Labor Agreement**" means any Collective Bargaining Agreement between the Union and any Employer, including any extension thereof or any new collective bargaining agreement which provides for contributions to the Fund.

"**Medically Necessary**" means:

A medical service or supply that is (as determined by the Plan Administrator or its designee):

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

A medical service or supply will be considered to be "Appropriate" if:

It is a diagnostic procedure that is called for by the health status of the patient, and is as likely to result in information that could affect the course of treatment as, and no more likely to produce a negative outcome than, any alternative service or supply, both with respect to the illness or injury involved and the patient's overall health condition.

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

- A medical service or supply will be considered to be "Cost-Efficient" if it is no more costly than any alternative appropriate service or supply when considered in relation to all health care expenses incurred in connection with the service or supply.
- The fact that your Physician or other Healthcare Provider may provide, order, recommend or approve a service or supply does not mean that the service or supply will be considered to be medically necessary for the medical coverage provided by the Plan.
- A medical service or supply that can safely and appropriately be furnished in a Physician's office or other less costly facility will not be considered to be medically necessary if it is furnished in a Hospital or Health Care Facility or other more costly facility.

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

A "**Mental Illness**" is an Illness defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol or psychiatric

drugs or medications, regardless of any underlying physical or organic cause. Certain disorders, conditions, and diseases are specifically excluded from coverage in the Exclusions and General Limitations section of this booklet.

"No Surprises Act" means the No Surprises Act (Public Law 116-260, Division BB).

"Non-PPO Emergency Facility" means an emergency department of a hospital, or an Independent Freestanding Emergency Department (or a hospital, with respect to Emergency Services as defined), that does not have a contractual relationship directly or indirectly with a group health plan or group health insurance coverage offered by a health insurance issuer, with respect to the furnishing of an item or service under the plan or coverage respectively

"Non-PPO Provider" means a health care provider who does not have a contractual relationship directly or indirectly with the Plan with respect to the furnishing of an item or service under the Plan.

"Out-of-Network Rate" with respect to items and services furnished by a Non-PPO Provider, Non-Network emergency facility or Non-PPO Provider of ambulance services, means one of the following:

- The amount the parties negotiate;
- The amount approved under the independent dispute resolution (IDR) process; or
- If the state has an All-Payer Model Agreement, the amount that the state approves under that system.

The term "**Participant**" means an eligible Active Employee, employees of the Local Union for whom contributions are made to the Trust Fund under the terms of a Subscriber Agreement approved by the Board of Trustee, a Retired employee or any of their eligible Dependent Spouses, Domestic Partners or Dependent Children.

The term "**Plan Administrator**" means the Board of Trustees of the ***California Service Employees Health and Welfare Trust Fund***. The Plan Administrator contracts with a Third Party Administrator to process claims and handle the day to day administrative functions of the Trust Fund.

The term "**Plan Documents**" refers to the written documents, insurance policies, HMO policies, Evidence of Coverage documents, this **Summary Plan Description**, Collective Bargaining Agreements, and all other legal documents setting forth the benefits offered by the ***California Service Employees Health and Welfare Trust Fund***. It also includes written policy and procedure documents that have been formally adopted by the Board of Trustees.

The terms "**Physician**" or "**Surgeon**" or "**Doctor**" mean a licensed Doctor of Medicine (M.D.), or Doctor of Osteopathy (D.O.). The term Physician shall not include any person who is the spouse, child, brother, sister, or parent of the Active or Retired Employee.

A "**Qualified Medical Child 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. The Fund Office will forward any such order that it may receive to the Fund's Legal Counsel to determine whether the medical child support order is a Qualified Medical Child Support Order.

"Qualifying Payment Amount (QPA)" means the amount calculated using the methodology described in 29 CFR 716-6(c).

"Recognized Amount" means (in order of priority) one of the following:

1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act;
2. An amount determined by a specified state law; or
3. The lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA)

For Air Ambulance Services furnished by Non-PPO Providers, **Recognized Amount** is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount (QPA).

"Serious and Complex Condition" means with respect to a participant, beneficiary, or enrollee under the Plan one of the following:

1. In the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent;
2. In the case of a chronic illness or condition, a condition that is—
    a. Is life-threatening, degenerative, potentially disabling, or congenital; and
    b. Requires specialized medical care over a prolonged period of time.

In the context of Continuity of Care, **Termination** includes, with respect to a contract, the expiration or nonrenewal of the contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud.

"Skilled Nursing Facility (SNF)" under this Plan 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 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, assisted living care facility, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, mentally ill; and
- It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital, as defined in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

The term "**Totally Disabled**" for purposes of extension of eligibility for medical benefits, means, with respect to an Active Employee, that due solely to Injury or Illness, he/she is prevented from engaging in any and every duty of their regular or customary occupation or employment and is performing no work of any kind for wage or profit. With respect to a covered Dependent, this means that due solely to an Injury or Illness, he/she is prevented from engaging in substantially all of the normal activities of a person of like age and like sex who is in good health. Note that if you are eligible for life insurance, you should refer to the ***Group Insurance Plan*** brochure from the insurance underwriter for the definition of disability as it applies to life insurance.

"**Union**" means the Service Employees International Union, including local affiliates accepted as participating local unions by the Board of Trustees in their sole discretion.

"**Utilization Management**" means 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 Utilization Management services are provided by licensed health care professionals employed by the Utilization Management Company operating under a contract with the Plan.

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