Bay Area Delivery Drivers Security Fund

Plan Document/Summary Plan Description
Plan 7

Amended, restated and effective April 1, 2018

Bay Area Delivery Drivers Security Fund

Plan Document/Summary Plan Description

Plan 7

Amended, restated and effective April 1, 2018

TABLE OF CONTENTS

INTRODUCTION

What This Document Tells You

This booklet is the "Plan Document" and Summary Plan Description describing Bay Area Delivery Drivers Security Fund Plan 7, which covers Medical, Prescription Drugs, Mental Health, Alcohol and Chemical Dependency Treatment, Dental, Vision, Short Term Disability, Life and Accidental Death and Dismemberment and Survivor Income Insurance. The Bay Area Delivery Drivers Security Fund is hereafter referred to as "BADD" or "the Fund" and Plan 7 is referred to as "the Plan." The Plan described in this document is effective January 1, 2018, and replaces all other plan documents, summary plan descriptions and benefit inserts previously provided to Plan Participants. This Summary Plan Description ("SPD") is the "Plan Document" for purposes of the Employee Retirement Income Security Act of 1974 (ERISA). This SPD refers to the Employee whose Employer pays into the Plan as "the Participant" and/or "you."

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. Vested rights refers to benefits that an individual has earned a right to receive and that cannot be forfeited. Plan benefits are not vested and are not guaranteed. The Board of Trustees reserves the right to change, reduce or terminate these benefits at any time.

Please note that while there are many benefits associated with this Plan, not every expense you incur for health care will be covered by the Plan.

If you have any questions about your coverage or your obligations under the terms of the Plan, be sure to seek help or information from the appropriate source. A Quick Reference Chart that includes sources of help or information about the Plan appears in this chapter. For purposes of medical benefits, **once you become eligible. You will be asked to choose between the Fund's self-insured Anthem Blue Cross Preferred Provider option and the Kaiser HMO Plan.**

IMPORTANT INFORMATION

The Bay Area Delivery Drivers Security 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 coverage 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 ERISA, the federal law governing employee benefits. The Indemnity Medical Plan (including Prescription Drugs), mental health, chemical dependency, dental, vision and short term disability benefits of the Plan are self-funded with Contributions from Employers and Eligible Employees held in a Trust used to pay Plan benefits. An independent Fund Administrator pays benefits out of Trust assets. The Kaiser HMO medical plan, life and accidental death and dismemberment and the survivor income benefits of the Plan are fully insured with insurance companies whose names are listed on the Quick Reference Chart in this document found on page 3.

Questions You May Have

We have done our best to present this information in a comprehensive, straightforward manner that is easy to understand. If you need additional information, you may contact the Fund Administrator by telephone at 800-654-1824 or 925-833-7300. As a convenience to you, the Fund Administrator will provide answers on the telephone on an informal basis. However, the answers supplied by the Fund Administrator are not binding on the Board of Trustees, who have sole discretion to interpret and apply the Plan. Only the Board of Trustees is authorized to interpret the Plan described in this booklet. No individual Trustee, Employer or union representative is authorized to interpret the Plan on behalf of the Board of Trustees or to act as an agent of the Board of Trustees.

Affordable Care Act ("ACA")

This Plan is a non-grandfathered plan under the ACA (also known as the "Patient Protection and Affordable Care Act," "PPACA," and "Obamacare") and is subject to many (but not all) of the requirements of the ACA applicable to group health plans.

FOR HELP OR INFORMATION

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

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Fund Administrator /Fund Office • Claim Forms (Indemnity Medical Plan and Dental) • Indemnity Medical Plan (including Mental Health) and Dental Claims and Appeals • Eligibility for Coverage • Benefit Information • Covered wellness/preventive benefits Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC) • Adding or Dropping Dependents • COBRA Continuation Coverage (including cost, eligibility, second Qualifying Event and Disability Notification) • Short Term Disability (STD) Income • Filing a life insurance or accidental death and dismemberment claim (AD&D). • Filling out a Beneficiary form for life insurance, AD&D and Survivor income benefits	**Health Services and Benefit Administrators, Inc. (HSBA)** Bay Area Delivery Drivers Security Fund 4160 Dublin Blvd., Suite 400 Dublin, CA 94568 Phone: (800) 654-1824 or (925) 833-7300 Fax: (925) 833-7301
PPO Network/Preauthorization Review Vendor (for the medical PPO Plan) • Medical and Mental Health Network Provider Directory • Additions/Deletions of Network Providers **(always check with your provider or Anthem before you visit a provider to be sure they are still in the network)** • Preauthorization of inpatient admissions • Appeals of Utilization Management decisions	**Anthem Blue Cross of California** Prudent Buyer Plan 1-800-688-3828 Website for provider directory: www.anthem.com/ca **CAUTION:** Use of a **Non-PPO** network Hospital, facility or practitioner could result in you having to pay a substantial balance of the provider's billing. This is known as "Balance Billing" and occurs when a healthcare provider bills a patient for charges (other than copays, coinsurance, or Deductibles) that exceed the Plan's payment for a covered service. **You will incur the lowest out of pocket costs when you use In-Network PPO providers**.
Prescription Drug Program for the medical PPO Plan administered by the Prescription Benefit Manager (PBM) (Kaiser Participants' Prescription Drug benefits are through Kaiser) • ID Cards • Retail Network Pharmacies • Mail Order (Home Delivery) Pharmacy • Prescription Drug Information	**OptumRx** 1-800-797-9791 www.optumrx.com
Health Maintenance Organization (HMO) • Medical, Mental Health and Substance Abuse and Prescription Drugs	**Kaiser Permanente** Corporate Office 1950 Franklin Street Oakland, CA 94612 Member services: 1-800-464-4000

QUICK REFERENCE CHART	
Information Needed	**Whom to Contact**
Dental PPO Network • Dental Provider Directory • Additions/Deletions of Network Providers **(always check with your provider or Premier Access before you visit a provider to be sure they are still in the network)**	**Premier Access** www.premierlife.com, click on the "Find a Dentist" button at the top of the page and choose the "Commercial Plans – Dental PPO" Selection on the "Select Plan" dropdown menu.
Vision Plan • Vision Network and Provider Directory • Vision Claims and Appeals	**VSP** (800) 877-7195 Website for Network Provider Directory: www.vsp.com
Substance Abuse Program for the Indemnity Medical Plan Participants only (Kaiser Participants' Substance Abuse benefit through the Kaiser HMO). • Call to be directed to a TAP Substance Abuse and Chemical Dependency providers • Substance Abuse and Chemical Dependency Claims	**Teamsters Assistance Program of Northern California (TAP)** 80 Swan Way, Suite 320 Oakland, CA 94621 (510) 562-3600
Life, AD&D and Survivor Income Insurance • Call the Fund Administrator for a copy of the booklet that explains the full terms and conditions of these benefits.	**ReliaStar Life Insurance Company** Voya Financial 20 Washington Ave. South P.O. Box 20 Minneapolis, MN 55440-0020 Call the Fund Administrator with any questions at (800) 654-1824 or (925) 833-7300 If you die, your family or Beneficiary should notify the Fund Administrator immediately. To claim a dismemberment benefit, you or your representative should notify the Fund Administrator. The Fund Administrator will advise what forms and certificates need to be filed to apply for the life insurance benefit. The Fund Administrator will forward your claim to the insurance company for processing. You must file an appeal of a claim denial directly with ReliaStar Life Insurance Company.
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**Privacy Officer** **Bay Area Delivery Drivers Security Fund** 4160 Dublin Blvd., Suite 400 Dublin, CA 94568 Phone: (800) 654-1824 or (925) 833-7300 Fax: (925) 833-7301

ELIGIBILITY

Employee Eligibility

You are eligible to participate in the Bay Area Delivery Drivers Security Fund if:

- You are employed by an Employer who has a Collective Bargaining Agreement or an approved subscription agreement with a participating local union which provides for participation in a plan sponsored by the Fund,
- You work (or are compensated for) the minimum number of hours as required under the Collective Bargaining Agreement for your Employer to be obligated to contribute on your behalf,
- Your Employer contributes to the Fund on your behalf on time and in the full amount required by the Fund, and
- You have completed and submitted an enrollment form to the Fund.

Minimum Hours of Service Requirement

You are eligible to begin coverage under the Plan once you have met the Minimum Hours of Service Requirement as provided in the Collective Bargaining Agreement (and/or approved subscription agreement) between your union and your Employer.

You can begin coverage on the first day of the Calendar Month that follows the month in which you completed the service requirement. For most Plan Participants, this will be the first day of the month that follows the month in which you complete your 80th hour of service.

For example: if your first day of work is in May and your Collective Bargaining Agreement requires you to work 80 hours before you begin participating in the Plan *and* you complete 80 hours of work by May 15, your coverage would begin on June 1st (provided that your Employer makes the required Contribution and your contract does not exempt probationary Employees from the Contribution obligation).

Dependents' Eligibility

Your Dependents will be covered by the Plan when you establish eligibility or, if you are already enrolled in the Plan, when the Dependent becomes an eligible Dependent through birth, marriage, adoption, or forming a Domestic Partnership. You must make sure to *enroll* your eligible Dependents in the Plan within 31 days of becoming eligible by contacting the Fund Office. They will not be entitled to benefits until they are enrolled.

An eligible Dependent is:

- Your legal Spouse or your Domestic Partner.
- Children up to age 26 including:
  - ✓ your natural children;
  - ✓ your stepchildren (including children of your Domestic Partner) who live in your household;
  - ✓ legally adopted children on the date they are placed with you in your home in anticipation of final adoption;
  - ✓ children for whom you have been appointed Legal Guardianship;
  - ✓ foster children;
  - ✓ children designated as your Dependents in a valid and approved Qualified Medical Child Support Order.
- **Adult Disabled Child:** Unmarried mentally or physically disabled children age 26 and older who are unable to support themselves and are primarily dependent on you for their support provided, (1) they were eligible and totally and permanently disabled before age 26; and (2) you furnished proof of the ongoing total and permanent disability within 31 days of your child reaching age 26 (and as may also be periodically required by the Fund after age 26).

Domestic Partners

Domestic partners are defined as same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such registrations. There are no requirements for proof of relationship or waiting periods that are not also applied to married couples. For your Domestic Partner to receive benefits, you must enroll in the Plan by submitting to the Fund Administrator:

- An application of enrollment; and
- A copy of the Certificate of Domestic Partnership (or equivalent form) issued to you and your Domestic Partner by a state or local government agency.

Tax Consequences of Domestic Partner Eligibility

Unless otherwise indicated, your Domestic Partner is eligible for coverage to the same extent coverage is available to a legal Spouse. However, federal tax laws require the Fund to determine how much of the monthly Employer Contribution to the Fund is attributable to the coverage of your Domestic Partner and to **report that amount as additional taxable income paid to you** unless you can show that for purposes of your federal income tax returns you have primary responsibility for your Domestic Partner's living expenses. In other words, if your Domestic Partner has a job or supports himself or herself through his or her own employment, you will have to pay the Employee payroll taxes each quarter on part of the monthly Employer Contribution paid on your behalf.

Your Employer must agree to pay any Employer payroll taxes on the value of your Domestic Partner coverage. The Fund Administrator will mail to you and your Employer a notice indicating the "fair market value" of the Domestic Partner coverage as well as a form for your Employer to fill out indicating either that it will pay its share of the payroll taxes for your Domestic Partner coverage or affirm that it does not consider your Domestic Partner's benefits as taxable income. You may also be asked to provide supporting documentation and/or complete an attestation form certifying that you are primarily responsible for your Domestic Partner's living expenses.

The fair market amount will vary from year to year but is likely to be 40% or more of the monthly Employer Contribution.

Termination of Your Domestic Partner's Eligibility

Your Domestic Partner's coverage, and the coverage of any Dependent Children of your Domestic Partner, terminates on the earliest of the following dates:

- The date you and/or your Domestic Partner terminate your Domestic Partnership;
- The date a Notice of Termination of Domestic Partnership is filed with the state or local government;
- The date a Petition to Terminate your Domestic Partnership is filed in Court;
- The date on which you are no longer eligible for coverage; or
- The date Dependent coverage for a Spouse or child would terminate under the terms of the Plan.

When Your Dependents' Eligibility Begins

If you have Dependents on the date you first become eligible to participate in the Plan, your Dependents also become eligible on that date (but you must still enroll them). If you are already enrolled when you acquire a new Dependent, please see the Special Enrollment section on page 9 for information on when your newly acquired Dependent becomes eligible.

Enroll in the Plan

Although you may be eligible to participate in the Plan, you must also take steps to *enroll* to receive plan benefits. **Benefits will not begin until the Fund Administrator's Office has received your enrollment form.** Enrollment forms can be obtained from the Fund Administrator and from the Union. To ensure that you are eligible for benefits as soon as you meet the eligibility requirements, you should submit your enrollment form before completing the minimum eligibility requirements.

As part of enrollment, you must provide copies of the following (as applicable):

- A marriage certificate for your Spouse,

- A Certificate and a Declaration of Domestic Partnership (or equivalent form) for your Domestic Partner,
- Birth certificates for each of your Dependent children,
- Certificates of adoption or the equivalent for any adopted children;
- For a foster child, the initial placement order or subsequent final orders placing the child in your foster care and the foster family placement contract you enter into with the applicable government agency;
- Proof of disability for an adult disabled child;
- For children over which you have Legal Guardianship, a copy of the court order granting you Legal Guardianship.

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 Fund Administrator 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: Applying for a social security number is FREE.

Failure to provide the SSN or failure to complete the CMS model form (which is available from the Fund Administrator or http://www.cms.gov/Medicare/Coordination-of-Benefits-and-Recovery/Mandatory-Insurer-Reporting-For-Group-Health-Plans/Downloads/New-Downloads/RevisedHICNSSNForm081809.pdf) means that claims for otherwise eligible individuals may not be considered a payable claim until your Dependent's SSN and CMS model form (if applicable) is received by the Plan.

Enrollment for Newly Eligible Active Employees

When you first become eligible for the Plan, you must select a medical plan option. You may choose between either the Indemnity Medical Plan and the Kaiser HMO Plan. **If you do not make a choice, you will be automatically enrolled in the Indemnity Medical Plan described in this SPD.**

If you are enrolled in the Indemnity Medical Plan, you can change to the Kaiser HMO option only during the annual Open Enrollment Period, described below.

When you enroll for medical benefits in the active plan, you are also enrolled for the following benefits:

- Dental Plan benefits (unless you elect to opt out of dental coverage).
- Vision Plan benefits.
- Employee Life Insurance and Survivor Income Benefits.
- Dependent Life Insurance (if applicable for your Spouse and/or eligible children).
- Accidental Death & Dismemberment (AD&D) Insurance (Employee only).
- Prescription Drug Coverage (unless you have elected Kaiser, in which case you will receive Prescription Drug coverage through Kaiser).
- Substance abuse/chemical dependency benefits (unless you have elected Kaiser, in which case you will receive substance abuse/chemical dependency benefits through Kaiser).

Option to Decline Dental Coverage

You have the option to decline the Plan's dental coverage. To decline coverage, complete the portion of the Plan's enrollment form related to declining dental coverage. Enrollment forms are available from the Fund Administrator.

- **Please note that your Employer's share (or your share, if you are required by your Collective Bargaining Agreement to pay a share) of the monthly Contribution for your health benefits will NOT be reduced if you choose to opt out of dental coverage.**

- If you decline dental coverage, you may re-enroll for such coverage after 12 months has lapsed, by contacting the Fund Administrator. The option to decline dental coverage is permitted once each 12-month period.

Initial Enrollment

You must enroll no later than 31 days (or 60 days in certain circumstances) after the date on which you are eligible for coverage by submitting a completed written enrollment form that may be obtained from the Fund Administrator, providing proof of Dependent status (as appropriate) and paying any required Contributions for coverage. If you want Dependent coverage, you must enroll your Eligible Dependents at the same time. If you do not enroll within the 31-day period, you may enroll your eligible Dependents at a later time. However, subsequent coverage will be effective the first day of the following month (on a prospective basis) after you enroll.

Failure to Enroll During Initial Enrollment

If you do not enroll yourself, or if you do not enroll any of your Eligible Dependents during the Initial Enrollment period (unless you and/or your Dependent(s) qualify for the Special Enrollment described in this chapter) you will only be able to enroll yourself and/or your Dependents prospectively. This means yours and your Dependent's coverage will not be retroactive to the date you were initially eligible for coverage. If you or your Dependent incur any claims before being enrolled in the Plan, the **Plan will not pay for those claims.**

Indemnity Medical Plan Default Provision:

If you fail to turn in your Open Enrollment benefit election forms indicating your selection of medical plan options, you and your eligible Dependents (if you have turned in all other required supporting documentation required for enrollment) will be enrolled in the Indemnity Medical Plan (including Prescription Drugs and chemical dependency treatment, Dental, Vision, Employee Life Insurance and Survivor Income Benefits and Accidental Death and Dismemberment coverage).

You must make a specific election on a separate HMO enrollment form to enroll in the Kaiser HMO medical plan option.

Open Enrollment

Open Enrollment Period: Open Enrollment is the period each year designated by the Board of Trustees during which eligible Employees and COBRA qualified beneficiaries may make the elections specified below. Enrollment forms and information may be obtained from the Fund Administrator.

Failure to Enroll During Open Enrollment

If you have been previously enrolled for coverage and you do not make a new election during the Open Enrollment period, you **and your enrolled Dependents will remain in the medical option that you are currently enrolled in (either the Indemnity Medical Plan or Kaiser), provided you continue to meet the Plan's "Maintaining Your Eligibility" provision described below.**

Kaiser HMO Health Plan

Once eligible, you must choose between Kaiser HMO coverage and the Indemnity Medical Plan benefits described in this booklet. A description of the benefits available through the Kaiser HMO will be provided during the Open Enrollment Period or may be obtained by contacting Kaiser at the number listed on the Quick Reference Chart.

If you choose to be covered under the Kaiser HMO, Kaiser will also be your coverage for:

- Prescription Drugs; and
- Alcohol and chemical dependency treatment.

Any other benefits for which your group is eligible will be provided through the Fund.

A complete Evidence of Coverage (EOC) for the Kaiser HMO benefits can be obtained by contacting Kaiser at the telephone number listed on the Quick Reference Chart at the beginning of this SPD.

HMO Open Enrollment Requirements

You and your eligible Dependents will be covered by the Indemnity Medical Plan unless you timely elect the Kaiser HMO option**. You must make this election on a separate HMO enrollment form**. Send your completed HMO enrollment form to the Fund Administrator (not directly to Kaiser) for processing. The election you make applies to your entire family. If you do not choose HMO coverage when you first become eligible for coverage, you will have to wait until the next annual Open Enrollment Period to elect HMO coverage (unless you have a Special Enrollment event as outlined below). The Open Enrollment Period is ordinarily during the month of July, but will be determined by the Board of Trustees on an annual basis.

Provided that you keep the Fund aware of any changes in your home address, you will receive a notice, normally in June of each year, of your option to change to the HMO plan, and instructions regarding how to receive additional enrollment literature and forms for changing your provider. You may request from the Fund Administrator, a packet explaining your options and containing a change request form.

You can elect to switch from the Kaiser HMO Plan to the PPO plan at any time during the year by contacting the Fund Administrator. If the change is outside the 30-day window (or 60 days in certain circumstances), the change will be effective the first day of the month following the month you made the change.

Designating your Beneficiary

Several Plan benefits, including the Life Insurance, Accidental Death and Dismemberment and Survivor Income Life Insurance benefits require you to designate a Beneficiary in the event of your death. When you enroll in the Plan, you should fill out and submit the Beneficiary designation form. Your designation will determine who receives these benefits if you die. If you have not designated a Beneficiary, the Plan will follow the rules on page 54 of this booklet regarding your default Beneficiary.

Maintaining your Eligibility

After you have met the initial eligibility requirements, you will maintain your eligibility from one month to the next if:

- You have worked the number of hours required under the Collective Bargaining Agreement between your union and Employer (typically 80 or more hours in a month) and your Employer makes the required Contribution to the Fund on time and in full on your behalf, as required in its Collective Bargaining Agreement; or
- You are not working, but the Collective Bargaining Agreement still requires your Employer to make payments on your behalf (because you are on leave, disability, etc.); or
- You have continued coverage by self-payment; or
- You qualify for continuation of health plan coverage due to Total Disability.

Contributions paid for hours worked in one-month pay for coverage for the following month. For example, when your Employer makes Contributions on your behalf for the hours you worked in March, this Contribution pays for your coverage for April.

Paid time off, such as vacations, sick leave and holidays, are counted as 'work hours' for eligibility purposes, and your Employer is still obliged to contribute to the Fund on your behalf during such periods (unless the Collective Bargaining Agreement specifically states otherwise).

Special Enrollment

New Spouse and/or Dependent Child(ren) **If you get married** (whether or not you are currently enrolled in coverage) you may request special enrollment for you, your new Spouse and/or any Dependent Child. You must request this special enrollment within30 days after the date of marriage, Coverage will be effective no later than the first day of the first Calendar Month beginning after the Plan has received your request for special enrollment. You will need to provide the appropriate documentation for each applicable Dependent as described on page 5.

If you acquire a new child either through birth, adoption or placement for adoption (whether or not you are currently enrolled in coverage), you can request special enrollment for you, your Spouse (whether or not he/she is currently enrolled in coverage), your new child, and/or any other Dependent Children. You must request this special enrollment within 30 days after the date of birth, adoption or placement for adoption. Your coverage, your Spouse's

coverage and/or your Dependent Child's coverage will begin on the date of birth, adoption or placement for adoption (as applicable). **If you do not request this special enrollment within 30 days of birth, adoption or placement for adoption then enrollment will be prospective only, and not retroactive to birth, adoption, or placement for adoption.**

Loss of Other Coverage

If, you did not enroll under this Plan or did not enroll your Spouse, Domestic Partner, the Domestic Partner's Children, and/or any Dependent Child(ren) within **31 days** after the date on which coverage under the Plan was previously offered because you or they had health care coverage under another group health plan or health insurance policy including COBRA Continuation Coverage, certain types of individual health insurance (including coverage purchased through a Health Exchange or Marketplace such as Covered California), Medicare, Medicaid, or other public program) **and** you, your Spouse, Domestic Partner and/or any Dependent Child(ren) **lose coverage** under that other group health plan or health insurance policy; you may request enrollment for yourself and/or your Spouse, your Domestic Partner, the Domestic Partner's children and/or any Dependent Child(ren) within **31 days** after the termination of their coverage under that other group health plan or health insurance policy for coverage retroactive to the date the date your Spouse, Domestic Partner, and/or Dependent Child lost health care coverage. If you do not enroll your Spouse, Domestic Partner and/or Dependent Child within 31 dates from the date that individual lost health care coverage, his or her subsequent coverage will be prospective only.

Medicaid or a State Children's Health Insurance Program (CHIP):

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

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

Qualified Medical Child Support Orders (QMCSO) (Special Rule for Enrollment)

This Plan will provide benefits in accordance with a **Qualified Medical Child Support Order ("QMCSO")** or a **National Medical Support Notice** which creates, recognizes or assigns a child's right to receive benefits as your covered Dependent. When the document providing for coverage of a child as your Dependent is submitted to the Fund, the Fund will review the Order to determine whether it satisfies the legal requirements for a QMCSO (in other words, whether it is "qualified") or a National Medical Support Notice.

QMCSOs should be sent to the Fund Administrator. The child named in the QMCSO will be enrolled in the Plan option you are enrolled in, unless the QMCSO specifies a particular option.

For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Fund Administrator.

When Coverage Ends

Employee coverage **ends on the earliest** of the following:

- The date the Plan terminates,
- The end of the month for which the last Employer Contribution is made on your behalf,
- The 32nd day after you enter the U.S. armed services on a full-time basis (if you fail elect to self-pay as described on 13).
- The date your eligibility for coverage ends as described under "Continuation Coverage",
- The date your Employer ceases to be a Participating Employer, or
- The date you retire, are pensioned, leave voluntarily, or are dismissed from employment, or the date you otherwise stop active work for your Employer.

Dependent Coverage **ends on the earliest** of the following:

- The date your Dependent ceases to be an eligible Dependent under the Plan (for example, for your Spouse upon divorce),
- The last day of the month in which your children reach the Plan's maximum age allowed for Dependent Children,
- The date your coverage terminates,
- The date your Spouse or Domestic Partner enters the U.S. armed services on a full-time basis, or
- The date the Plan terminates, or the date the Plan terminates coverage for Dependents.

Surviving Dependents

If you are an Active Employee and you die leaving only your Spouse or Domestic Partner, he/she will remain eligible for up to **twenty-four (24) months after your death** (starting with the first day of the month immediately following the date of your death) or until he or she remarries or enters into another Domestic Partnership. If you die leaving only Dependent Children, they will remain eligible for up to two years or until he or she no longer qualifies as a Dependent child, whichever occurs first.

If you die leaving both a Spouse (or Domestic Partner) ***and*** Dependent child(ren), your children's eligibility will be based on your surviving Spouse's or Domestic Partner's participation. For example, if you die and your Spouse remarries one year later, your Dependent Children will also lose their coverage on the date of marriage.

Please contact the Fund Administrator for information regarding the cost of this coverage.

Note that these extensions of coverage for a Spouse and children run concurrently with any COBRA rights that may exist, not in addition to such rights. At the end of the two-year extension described here, your Spouse, Domestic Partner or child may remain eligible to continue coverage through COBRA.

Options When Your Coverage under This Plan Ends

When coverage under this Plan terminates, you may have the option to self-pay for temporary continuation of this group health plan coverage by electing COBRA Continuation Coverage. You can also look into your options to buy an individual insurance policy for health care coverage from the **Health Insurance Marketplace**.

If you purchase coverage in the Marketplace, you could be eligible for a premium tax credit that would lower your monthly premium for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a premium tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov or www.coveredcalifornia.com (for California residents). You may also qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that plan within 30 days of losing coverage under this Plan.

When the Plan Can End Your Coverage for Cause

In accordance with the requirements in the Affordable Care Act, the Plan will not retroactively cancel coverage (a rescission) except when Contributions and self-payments are not timely paid, or in cases when an individual performs an act, practice or omission that constitutes fraud, or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan, or as otherwise allowed by federal law.

Family and/or Medical Leave (FMLA)/California Family Rights Act (CFRA)

The federal Family Medical Leave Act (FMLA) and the state of California's California Family Rights Act (CFRA) provide that if you work for an Employer covered by the FMLA or CFRA you are entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a child, to provide care for a Spouse, child or parent who is seriously ill, or for your own Illness for up to 12 weeks a year (in some cases, up to 26 weeks). In general, the Employers covered by FMLA and CFRA are those who employ 50 or more Employees for each working day during each of twenty or more calendar weeks in the current or preceding Calendar Year. If you are taking FMLA or CFRA leave that has been approved by your Employer, your Employer is responsible for making Contributions to the Fund on your behalf, as if you are working, in order to maintain your eligibility. To find out

more about Family or Medical Leave under the FMLA and CFRA, the interaction between the two laws and the terms on which you may be entitled to leave, contact your union or Employer.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

A Participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about your rights to continuation coverage and reinstatement of coverage under USERRA.

What is USERRA?

USERRA Continuation Coverage is a temporary continuation of coverage when it would otherwise end because the Employee has been called to active duty in the uniformed services. USERRA protects Employees who leave for and return from any type of uniformed service in the United States armed forces, including the Army, Navy, Air Force, Marines, Coast Guard, National Guard, National Disaster Medical Service, the reserves of the armed forces, and the commissioned corps of the Public Health Service.

Normally, an Employee's coverage under this Plan will terminate when the Employee enters active duty in the uniformed services however:

- If the Employee elects USERRA temporary continuation coverage, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for **up to 24 months** measured from the date the Employee stopped working.
- If the Employee goes into active military service for **up to 31 days**, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.

Duty to Notify the Plan

The Plan will offer the Employee USERRA continuation coverage only after the Fund Administrator has been notified by the Employee in writing that they have been called to active duty in the uniformed services. The Employee must notify the Fund Administrator as soon as possible, but no later than 60 days after the date on which the Employee will lose coverage due to the call to active duty, unless it is impossible or otherwise unreasonable to give such notice.

Plan Offers Continuation Coverage: Once the Fund Administrator receives notice that the Employee has been called to active duty, the Plan will offer the right to elect USERRA coverage for the Employee (and any eligible Dependents covered under the Plan on the day the leave started). Unlike COBRA Continuation Coverage, if the Employee does not elect USERRA for the Dependents, those Dependents cannot elect USERRA separately. Additionally, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may also be eligible to elect COBRA temporary continuation coverage. Note that USERRA is an alternative to COBRA (either COBRA or USERRA continuation coverage can be elected and that coverage will run simultaneously, not consecutively). Contact the Fund Administrator to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Plan in the same timeframes as is required under COBRA (see page 86).

Paying for USERRA Coverage:

- If the Employee goes into active military service for up to **31 days**, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) can continue health care coverage under this Plan during that leave period.
- If the Employee elects USERRA temporary continuation coverage, the Employee (and any eligible Dependents covered under the Plan on the day the leave started) may continue Plan coverage for up to **24 months** measured from the date the Employee stopped working. USERRA continuation coverage operates in the same way as COBRA coverage and premiums for USERRA coverage will be 102% of the cost of coverage. Payment of USERRA and termination of coverage for non-payment of USERRA works just like with COBRA coverage.

In addition to USERRA or COBRA coverage, an Employee's eligible Dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). This plan coordinates benefits with TRICARE. You should carefully review the benefits, costs, provider networks and restrictions of the TRICARE plan as compared to USERRA or COBRA to determine whether TRICARE coverage alone is sufficient or if temporarily continuing this Plan's benefits under USERRA or COBRA is the best choice.

After Discharge from the Armed Forces:

When the Employee is discharged from military service (not less than honorably), eligibility will be reinstated on the day the Employee returns to work provided the Employee returns to employment within:

- 90 days from the date of discharge from the military if the period of services was more than 180 days; or
- 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days; or
- the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days.

If the Employee is Hospitalized or convalescing from an injury caused by active duty, these time limits are extended up to two years.

The Employee must notify the Fund Administrator in writing within the time-periods listed above. Upon reinstatement, the Employee's coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had the coverage not terminated.

Questions regarding your entitlement to USERRA leave and to continuation of health care coverage should be referred to the Fund Administrator.

Medical Extension of Benefits for Disability

If you or your Dependent is Totally Disabled at the time your active coverage ends, or at the time of your COBRA qualifying event, and you do not elect COBRA continuation coverage, the Plan will extend coverage for up to twelve months, **but coverage will only extend to services required for the treatment of the Illness or injury causing the disability.** The twelve-month period begins on the first day of the month. Coverage will continue without Employer payment for up to twelve months, but will terminate the earliest of:

- When the Total Disability ceases, or
- When you or your disabled Dependent begins to receive coverage under another health plan, or
- One year after the extension of benefits starts (i.e., the last day of the twelve-month period following the date of extension).

Continuation of Coverage

See the COBRA chapter beginning on page 84 for information on temporarily continuing your health care coverage.

INDEMNITY MEDICAL PLAN BENEFITS

Eligible Medical Expenses

You are covered for expenses you incur for most, but not all, medical services and supplies. The expenses for which you are covered are called "eligible medical expenses." Eligible medical expenses are determined by the Plan Administrator or its designee, and are limited to those that are:

1. **"Medically Necessary,"** but only to the extent that the charges are **"Allowed Charges"** (as those terms are defined in the Definitions chapter). The fact that a Physician prescribes or orders the service does not, in itself, make it Medically Necessary or a covered expense; and
2. **Services or supplies that are NOT excluded** from coverage (as provided in the Exclusions chapter of this document); and
3. **Services or supplies NOT in excess** of a Maximum Plan Benefit as shown in the Schedule of Medical Benefits; and
4. **For the diagnosis or treatment of an injury or Illness** (except where wellness/preventive services are payable by the Plan as noted in the Schedule of Medical Benefits in this document); and
5. **Incurred while you or your Dependents are covered under this plan**. An expense is incurred on the date you or your Dependents receive the service or supply for which the charge is made.

Even where an expense is for an Eligible Medical Expense, you are responsible for payment of Deductibles, coinsurance or copayments. For more information concerning your out-of-pocket costs, see the Plan's Schedule of Medical Benefits beginning on page 17 of this booklet.

In-Network Providers

If you receive medical services or supplies from a health care provider within the Plan's PPO Network, you will be responsible for paying less out- of- pocket because health care providers who are under a contract with the PPO have agreed to accept the discounted amount the Plan pays for covered services. You are responsible for paying any copayments, Deductibles or coinsurance.

Out-of-Network Providers

If you receive medical services or supplies from a health care provider that is not in the Plan's PPO Network (an "Out-of-Network Provider"), the health care provider will not generally offer any fee discount to you or to the Plan. These Out-of-Network Providers **may bill you for a non-discounted amount** for any balance that may be due that is **in addition to** the Allowed Charge paid by the Plan. This is, called "Balance Billing". Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or Deductibles) that exceed the Plan's payment for a covered service. **To avoid Balance Billing, use In-Network providers**.

This also applies to Out-of-Network facilities including, but not limited to Hospitals, ambulatory surgery centers, dialysis centers, skilled nursing facilities, Home Health Care providers, Hospice providers, specialty providers, and substance abuse facilities.

USE PPO PROVIDERS TO SAVE MONEY

When you need care, save money by seeing an In- Network or PPO provider. The cost-savings can be substantial, even thousands of dollars, depending on the level of medical care needed. This is because PPO Network doctors, Hospitals, labs outpatient centers, etc. (called In- Network or PPO providers) have agreed to accept a certain price for the type of care they provide and they cannot bill you or the Plan for more than this amount.

ALWAYS ASK IF A PROVIDER IS AN IN-NETWORK PROVIDER

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

THREE WAYS TO MAKE SURE YOU ARE USING NETWORK PROVIDERS

1. Log in to www.anthem/ca.com *or access Anthem's mobile app on your smartphone. Pick the* ***Find a Doctor*** *tool to search for* In-N*etwork providers and facilities.*

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

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

Deductibles

The annual Deductible is the amount you must pay each Calendar Year before the medical Plan begins to pay any benefits. Each Calendar Year, you (and **not** the Plan) are responsible for paying all of your eligible medical expenses until you satisfy the annual Deductible at which point the Plan will begin to pay benefits. There are two types of annual Deductibles: Individual and Family.

- The **Individual Deductible i**s the maximum amount one covered person has to pay toward Eligible Medical Expenses before Plan benefits begin.
- The **Family Deductible** is the maximum amount that a family is responsible for paying toward Eligible Medical Expenses before Plan benefits begin. Once two covered individuals in your family have met the deductible, you will have satisfied the maximum deductible for your entire family.

End-of-Year Deductible Carryover

If you incur charges during the last three months of a Calendar Year that are applied toward satisfying the Deductible for that year, those charges will also be applied toward your Deductible for the next Calendar Year. Please note that this carryover provision applies only to an individual Deductible, not the family Deductible.

Common-Accident Deductible

If you and your covered Dependents incur covered medical charges as a result of injuries suffered in a common Accident, just one Deductible will be applied during each Calendar Year to those charges. This common Accident provision will not apply if greater medical benefits would be paid in the absence of this provision.

Coinsurance

Once you have met your annual Deductible, the Plan generally pays a percentage of the Eligible Medical Expenses, and you (not the Plan) are responsible for paying the rest. The part you pay is called **coinsurance**. For a description of the coinsurance related to a particular covered benefit or service, see the Schedule of Medical Benefits.

Copayment

A **copay** is a set dollar amount you (not the Plan) are responsible for when you incur certain expenses. For a description of the copay related to a particular covered benefit or service, see the Schedule of Medical Benefits.

Out-of-Pocket Limit (for Deductibles, Copays and Coinsurance)

The **Out-of-Pocket Limit** is the most you or your family will pay during a one-year period (the Calendar Year) before your health plan starts to pay 100% for covered benefits. This Plan has an **Out-of-Pocket Limit**, which limits your annual cost-sharing for covered health benefits received from In-Network and Out-of-Network providers related to medical plan Deductibles, copays and coinsurance and a separate Out-of-Pocket Limit for In-Network Prescription Drugs. The amounts of these Out-of-Pocket Limits is described in your Schedule of Medical 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 Out-of-Pocket Limit may be adjusted annually, in accordance with guidance published by the Department of Health and Human Services.
- The family out-of-pocket limit includes cost-sharing for every covered family member; however, no one individual in the family will be required to pay more than the individual out-of-pocket limit.

- The Plan has a separate **Out-of-Pocket Limit** for covered outpatient In-Network Prescription Drugs purchased at a retail pharmacy. Once you meet your annual Prescription Drug **Out-of-Pocket Limit**, covered Prescription Drugs will be paid at 100% for the remainder of the Calendar Year. This Out-of-Pocket Limit will accumulate separately than the Out-of-Pocket limit for covered medical benefits.

Out-of-Pocket Limits do NOT include:

- The amount you pay (if anything, based on your Collective Bargaining Agreement) to the Plan's monthly premium,
- Expenses for dental or vision services or supplies,
- **Charges in excess of the Allowed Charge (as determined by the Plan) which includes balance billed amounts for Out-of-Network providers,** and
- Acupuncture and Non-Network outpatient Prescription Drugs.

Information about Medicare Part D Prescription Drug Plans for People with Medicare

If you and/or your Dependent(s) are entitled to Medicare Part A or enrolled in Medicare Part B, you are also eligible for Medicare Part D Prescription Drug Plan (PDP) benefits. **It has been determined that the Prescription Drug coverage outlined in this document is "creditable,"** this 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.

Because this Plan's Prescription Drug coverage is generally as good as Medicare Drug coverage, you do not need to enroll in a Medicare Part D Prescription Drug Plan. If you lose your coverage in the Plan, you may enroll in a Medicare Part D Prescription Drug Plan during Medicare's annual enrollment period,

You can keep your current medical and Prescription Drug coverage with this Plan and you do not have to enroll in Medicare Part D. If, however, you keep this Plan coverage and also enroll in a Medicare Part D Prescription Drug Plan, you will have dual Prescription Drug coverage and this Plan will coordinate its Drug payments with Medicare. See the Coordination of Benefit chapter for more details on how the Plan coordinates with Medicare. If you enroll in a Medicare Part D Prescription Drug Plan, you will need to pay the Medicare Part D premium out of your own pocket.

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

Designation of a Primary Care Physician (PCP) Not Required

The Indemnity Medical Plan does not require the selection or designation of a primary care Physician (a "PCP"). You have the ability to visit any network or non-network health care provider; however, **the Plan will pay less of the bill from a non-PPO Network Hospital or doctor than it will for a PPO Network Hospital or doctor.**

You do not need prior authorization and/or a referral from the Plan or from any other person (including a primary care Physician) to receive care from a health care professional who specializes in obstetrics or gynecology. However, the health care professional may be required to obtain prior authorization for certain services described in this booklet and follow a pre-approved treatment plan, or procedures for making referrals.

Please see Kaiser's Explanation of Coverage for information relating to the selection of a Kaiser primary care Physician.

Nondiscrimination in Health Care

In accordance with the requirements of the Affordable Care Act, the Plan will allow Medically Necessary treatment for covered services from any provider that is licensed to provide such treatment by the State in which the services are provided. This change does not affect any other Plan rules, change the Plan's distinction between PPO Network and non-Network providers, nor change the way in which benefits are provided or paid for by the Plan.

Participation in Clinical Trials

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

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

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

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

Participation in clinical trials is limited to PPO provider, unless the clinical trial is only offered outside your state of residence or if no PPO provider will accept you for participation in the trial.

For purposes of coverage of routine costs associated with approved clinical trials, "routine costs" means services and supplies incurred by an eligible individual during participation in a clinical trial if such expenses would be covered for a Participant or Beneficiary who is not enrolled in a clinical trial. However, the Plan does not cover non-routine services and supplies, such as: (1) the investigational items, devices, services or Drugs being studied as part of the approved clinical trial; (2) items, devices, services and Drugs that are provided solely for data collection and analysis purposes and not for direct clinical management of the patient; or (3) items, devices, services or Drugs inconsistent with widely accepted and established standards of care for a patient's particular diagnosis.

An "approved clinical trial" means a phase I, II, III, or IV clinical trial conducted in relation to the prevention, detection, or treatment of cancer or other life-threatening disease or condition. The clinical trial's study or investigation must be (1) federally-funded (like a trial funded by the National Institutes of Health (NIH), the Centers for Disease Control and Prevention (CDC), the Agency for Health Care Research and Quality (AHCRQ), the Centers for Medicare and Medicaid Services (CMS)); or (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.

Schedule of Medical Benefits

A schedule of the Plan's Indemnity Medical Plan benefits appears on the following pages in a chart format. Deductibles, Out-of-Pocket Limits, Hospital Services (Inpatient) and Physician services are listed first because these categories of benefits apply to most (but not all) health care services covered by the Plan. They are followed by descriptions, appearing in **alphabetical** order, of all other benefits for specific health care services and supplies that are frequently subject to limitations and exclusions.

TIME LIMIT FOR INITIAL FILING OF HEALTH CLAIMS

Medical and dental claims received more than 12 months after the date of service will be denied as untimely. **Prescription Drug claims will be denied if not filed within 90 days of purchase.** If your claim is for Life, Survivor Income or AD&D benefits, a claim filed more than twelve months from the date the benefit accrued will be denied unless you can show that there was reasonable cause for your delay. In such cases, the Fund may require you to provide proof substantiating the reason for delay.

Please also see "Limitation On When A Lawsuit May Be Started" on page 77.

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***
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 Fund. • Only Eligible Medical Expenses can be used to satisfy the Plan's Deductibles. • The Deductible applies to all covered services except where otherwise noted.	• There are not independent Deductibles for In-Network and Out-of-Network charges. Both In-Network and Out-of-Network charges will apply to satisfy the Deductible. • If you and your covered Dependents incur medical covered charges as a result of injuries suffered in a common Accident, just one Deductible will be applied during each Calendar Year to those charges. • If you incur charges during the last 3 months of a Calendar Year that are applied toward satisfying the Deductible for that year, those charges will also be applied toward your Deductible for the next Calendar Year. Please note that this carryover provision applies only to an individual Deductible, not the family Deductible.	$100 individual Once two covered individuals in your family have met the deductible, you will have satisfied the maximum deductible for your entire family.	
Out-of-Pocket Limit (including Coinsurance and Deductible) for Medical 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.	• There are not independent Deductibles for In-Network and Out-of-Network charges. Both In-Network and Out-of-Network charges will apply to satisfy the Deductible. • The Out-of-Pocket Limit may be adjusted annually. • 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 the individual out-of-pocket limit. • Covered charges for acupuncture and charges in excess of Allowed Charges billed by out-of-network providers do not accumulate to the Out-of-Pocket Limit.	$3,100 Individual $5,000 family	
Out-of-Pocket Limit (for Prescription Drugs)	• Only Drugs purchased at in In-Network pharmacy count towards this Out-of-Pocket Limit. • Drugs purchased at a Non-Network pharmacy do **not** count towards the Out-of-Pocket Limit on Prescription Drugs.	$3,250 Individual $7,500 family	No Out-of-Pocket Limit
Hospital Services (Inpatient) • Room & board facility fees in a semiprivate room. • Specialty care units within the Hospital (e.g., intensive care unit, cardiac care unit). • Lab/x-ray/diagnostic services. • Related Medically Necessary ancillary services (e.g., prescriptions, supplies). • Newborn care. See also the Maternity services row in this Schedule. Please note that if your covered child has a baby, the Hospital newborn care is not covered.	• **Preauthorization is not required before an inpatient confinement. However, we strongly recommend Preauthorization before any non-emergency surgery because any days in the Hospital that are later determined not to have been Medically Necessary will be denied.** • Benefits for facility or anesthesia charges incurred for a child under age 7, for a person of any age who is severely disabled, or whose health would be at serious risk without the use of general anesthesia for purposes of dental treatment are covered. Private rooms are covered only if Medically Necessary or if the facility does not provide semi-private rooms. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Hospital are usually billed separately from the facility fee. See the "Physician" row of this Schedule below for how payments to Physicians for services performed in a Hospital are applied. • In the case of a true Medical Emergency, the Plan will pay Out-of-Network providers the same rate as it pays In-Network providers for Allowed Charges.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***
Physician and Other Health Care Practitioner Services Following is a list of covered Healthcare Practitioners. A Healthcare Practitioner will be covered if licensed and practicing within the scope of that license): • Physician (M.D. or D.O.) • Dentist, • Psychologist, • Physical therapist (if referred by a Physician), a speech therapist (if referred by a Physician) • Chiropractor, • Podiatrist, • Optometrist, • Optician, • Certified acupuncturist, or • Registered Nurse (RN), Nurse practitioner (NP) or Physician's assistant (PA). **If you are receiving care from a type of provider who is not listed above and intend to make a claim for benefits for such care, please call the Claim Administrator to determine if the care is covered.** • See also the Family Planning, Maternity and Wellness rows where certain women's preventive services are payable without cost-sharing when obtained from In-Network providers. • See also the Emergency Services row for payment of providers in an emergency room.	• No coverage for telephone consultations. • **Surgery Guidelines:** If two or more surgical procedures are performed at the same time, the covered medical charges will be limited to those incurred for the major procedure plus no more than 50% of those incurred for each lesser procedure that adds significant time or complexity. Surgical treatment includes normal follow-up care and the administration of any local, digital block, or topical anesthesia. Reduced benefits may be paid for other anesthetics administered by the operating or assisting surgeon. • You are not required to select a primary care Physician (PCP) or to obtain a referral or prior authorization before visiting an OB/GYN provider. • The Plan Covers Physician and other Health Care Practitioner professional services rendered in, o an office visit, o an acute care Hospital, o other places, such as an outpatient clinic, rehab facility or your home. • The charge for the professional services of a Nurse for private duty nursing, but only during a period for which the Fund Administrator validates a Physician's certification that: o those nursing services are Medically Necessary, and o for outpatient nursing, the covered person would be an inpatient at an acute care Hospital or other facility in the absence of those nursing services. • Physical therapy only covered if patient is referred to physical therapist by a Physician. • Speech therapy only covered if patient is referred to speech therapist by a Physician.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Acupuncture Services	• Maximum benefit of 50 sessions per Calendar Year • You pay any cost over $30/session • Acupuncture services do **NOT** accumulate to the annual Out-of-Pocket limit.	50% of Allowed Charges up to $30 per session	
Allergy Services • Allergy sensitivity testing, including skin patch or blood tests such as Rast or Mast. • Desensitization and hyposensitization (allergy shots given at periodic intervals). • Allergy antigen solution.	• Allergy services are covered only when ordered by a Physician. • The following allergy tests are **NOT** covered: cytotoxic, sublingual, and provocative neutralization testing.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Ambulance Services • **Emergency transportation** to or from a local Hospital for treatment of a medical Emergency or acute Illness.	Covers transportation when Emergency medical conditions require it, rather than transportation for convenience or comfort.	Coverage of 70% of In-Network Allowed Charges	Coverage of 70% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***
Behavioral Health Services (Mental Health Treatment) • See also the Chemical Dependency and Substance Abuse row for additional benefits. • Inpatient admissions. • Residential treatment program. • Outpatient visits.	• Behavioral Health **Residential Treatment Program** is covered for individuals needing treatment in a highly structured 24-hour therapeutic environment when care cannot be safely or effectively treated in a less intensive setting. A Residential Treatment Facility must be properly licensed in the state in which the facility operates. • **Tobacco Cessation support:** The Plan covers, at no cost for In-Network providers, 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 tobacco cessation counseling sessions of at least 10 minutes each (including telephone counseling, group counseling and/or individual counseling) (without precertification). In addition, all FDA-approved tobacco cessation medications are covered (including both prescription and over-the-counter medications) for a 90-day treatment regimen when prescribed by a health care provider without prior authorization. No coverage available for care with an Out-of-Network provider. • **Preauthorization is not required before an inpatient confinement. However, we strongly recommend obtaining Preauthorization because any days that are determined to be not Medically Necessary will not be paid.**	**Inpatient: Hospital and Residential Treatment Program:** 70% of In-Network Allowed Charges **Outpatient visits:** 70% of In-Network Allowed Charges **Tobacco cessation screening and counseling:** No charge	**Inpatient: Hospital and Residential Treatment Program:** 50% of Allowed Charges **Outpatient visits:** 50% of Allowed Charges **Tobacco cessation screening and counseling:** 50% of Allowed Charges
Chemical Dependency (Substance Abuse treatment)	**Please refer to the Chapter beginning on page 36 for a complete description of your substance abuse benefits.**		
Chiropractic (Spinal Manipulation) Services • Spinal Manipulation Services (from a Physician or Chiropractor) including related ancillary services (e.g., office visit, x-rays, Physical Therapy, diagnostic tests and acupuncture performed instead of or in addition to spinal manipulation, is subject to the limitations and Annual Maximum Plan Benefit shown in the Explanations and Limitations column.	• Covered medical charges for up to 15 outpatient visits per course of treatment (unless additional treatments are preauthorized as Medically Necessary). See the chapter on required preauthorizations.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Corrective Appliances (Prosthetic & Orthotic Devices) Coverage is provided for Medically Necessary Prosthetic and Orthotic devices as follows: • The charge for a prosthetic device (initial prosthetic device only). • The charge of a Physician or Healthcare Practitioner for casts, splints, surgical dressings, and other medical supplies. • Orthotics (limited to once every two years).	• Orthopedic shoes are **NOT** covered.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***
Diabetes Education Covered charges include a diabetes self-management training program that: • teaches a covered person the proper use of the equipment, supplies, and medications prescribed for the treatment of diabetes and/or • provides additional diabetes outpatient self-management training, education, and medical nutrition therapy.	• Diabetes self-management training, education, and medical nutrition therapy must be provided by a Physician, Nurse, dietitian, pharmacist, or other licensed health care provider who is licensed or registered to provide the diabetes training, education, or medical nutrition therapy.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***

Durable Medical Equipment (DME)
• Coverage is provided for:
  • rental (but only up to the allowed purchase price of the Durable Medical Equipment);
  • purchase of standard model equipment;
  • replacement of Medically Necessary Durable Medical Equipment is payable only if there is a change in the covered person's physical condition or if the equipment cannot be satisfactorily repaired at a lesser expense.
  • supplies that are necessary for the function of the Durable Medical Equipment are also covered so long as the equipment is Medically Necessary for the individual who is covered under this Plan.
• Durable medical equipment includes, but is not limited to, equipment such as Hospital beds, wheelchairs, traction apparatus, intermittent positive pressure breathing machines, non-dental braces, breast pump and supplies necessary to operate, and crutches.
• Covered medical charges include charges for the following equipment and supplies if they are not covered by your Plan's Prescription Drug program: blood glucose monitors and blood glucose testing strips, blood glucose monitors designed to assist the visually impaired, insulin syringes, visual aids (except eyewear) to assist the visually impaired with proper dosing of insulin, ketone urine testing strips, lancets and lancet puncture devices, pen delivery systems for the administration of insulin, podiatric devices to prevent or treat diabetes-related complications.
• Other covered charges include the charge of a Physician or Healthcare Practitioner for casts, splints, surgical dressings, and other medical supplies, oxygen, blood, blood products, anesthetics, or other medical supplies, orthotics (limited to once every two years), Insulin pumps and all related necessary supplies for the pump (limited to once every 2 years).
	The charge to rent or purchase Durable Medical Equipment (purchase of Durable Medical Equipment will be covered only if the purchase price of the equipment is less than the rental costs). Durable medical equipment is equipment that:
	• is designated for repeated use,
	• is mainly and customarily used for medical purposes, and
	• is not generally of use to a person in the absence of a disease or injury.
	The following are examples of equipment that are **not** covered by the Fund: Air conditioners, air purifiers, heat lamps, heating pads, bed boards, orthopedic shoes, gravity traction devices, exercise bicycles, weight lifting equipment, and specially equipped vans. In addition, Replacement or repair of a prosthetic device or of Durable Medical Equipment (except where explicitly noted in this SPD) is not covered. This is only a partial list of the types of equipment and devices the Fund does **not** consider Durable Medical Equipment and is provided for illustrative purposes.
	Cochlear implants are covered only if preauthorized by Anthem as Medically Necessary.
		Breast pump and necessary supplies:
		No charge
		Other covered DME:
		Covered at 70% of In-Network Allowed Charges
			Breast Pump, necessary supplies and other covered DME:
			Covered at 50% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***
Emergency Room Facility, Urgent Care Facility • Hospital emergency room (ER) for "Emergency Services" (as that term is defined by the Plan). • Ancillary charges (such as lab or x-ray) performed **during** the Emergency Room visit.	• Emergency Services do not require pre-authorization. • The Plan will pay Allowed Charges for Hospital-based Emergency Services performed Out-of-Network. • Non-emergency care outside the United States is **NOT** covered.	Coverage of 70% of In-Network Allowed Charges	**Emergency Room**: Coverage of 70% of Allowed Charges **Urgent Care:** Coverage of 50% of Allowed Charges
Family Planning, Reproductive, Contraceptive and Fertility Services • Sterilization services (e.g., vasectomy, tubal ligation, implants such as Essure) covered with no cost-sharing for female sterilization when performed by In-Network providers • FDA-approved contraceptives for women such as oral birth control pills/patch, emergency contraception, injectables (e.g., Depo-Provera, Lunelle), intrauterine device (IUD), cervical cap, contraceptive ring, diaphragm, implantable birth control device/service (e.g. Implanon, Nexplanon) including removal of IUD and implantable contraception are covered with no cost-sharing.	• Only the initial office visit: laboratory test, and screening laparoscopy for the purpose of determining the cause of the infertility are covered. There is no subsequent coverage to treat the infertility including but not limited to charges made for artificial insemination, in vitro fertilization, or any other treatment for infertility. • No coverage for reversal of sterilization procedures or condoms. • Certain contraceptives are available through the Prescription Drug Program (see the Drugs row of this Schedule). • The Plan will cover without cost-sharing at least one form of contraception in each of the methods that the FDA has identified for women in its current Birth Control Guide. This coverage includes the clinical services, patient education and counseling needed for provision of the contraceptive method. The Plan will also cover without cost-sharing a contraceptive service or item not otherwise covered if that service or item is determined by the individual's provider to be Medically Necessary.	**Female Contraceptives and Female sterilization procedures:** 100%, no Deductible. **Other covered services;** Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Home Health Care and Home Infusion Therapy Services • Part-time, intermittent **Skilled Nursing Care** services and Medically Necessary supplies to provide Home Health Care or home infusion services.	The Fund provides coverage for Home Health Care services provided by an approved Home Health Care agency. The Deductible does not apply to Home Health Care. For benefits to be payable: • the services must have been prescribed by a Physician, to be performed in your home, • the services must have been prescribed as Medically Necessary for the care and treatment of bodily injury or disease and • the services must be performed by or under the supervision of a person who is licensed, certified, or otherwise duly qualified to perform such services on the same basis as if the services had been performed in a Hospital. The benefits payable for such services will not exceed the amount that would have been payable had the services been performed in a Hospital. **Housekeeping and Custodial Care are not covered.**	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Hospice • Hospice services include benefits for both inpatient and home Hospice care, including palliative and supportive medical and nursing services.	• If a covered person is terminally ill with a prognosis of 6 months or less to live, the Fund will cover Medically Necessary services rendered by an approved Hospice agency. • Preauthorization is required. • Benefits will be payable only if the attending Physician establishes and reviews the treatment plan and submits the plan to the Claims Administrator for approval before services are provided.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***
Laboratory Services (Outpatient) • Technical and professional fees.	• Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient Laboratory Services are covered under the Hospital Services section of this Schedule of Medical Benefits. • Fees associated with outpatient surgery or inpatient confinement will be paid at the same coinsurance as the associated service. • Some laboratory services are payable under the Wellness/Preventive care benefits in this Schedule.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Maternity Services • Hospital and Birth (Birthing) Center charges and Physician and Certified Nurse Midwife fees for Medically Necessary maternity services. • Elective abortion for Employee and Spouse only. • See the Eligibility chapter on how to enroll a Newborn Dependent Child(ren). • Breastfeeding equipment (breast pump) and supplies needed to operate the pump are paid for without cost-sharing (as noted on the Durable Medical Equipment row of this Schedule). • In conjunction with birth, the Plan pays for comprehensive lactation support and counseling (including breastfeeding classes) by a trained provider during pregnancy and/or in the postpartum period, with no cost sharing, when provided by an In-Network provider. • Normal radiology cost-sharing applies to ultrasound services. See the Radiology row of this Schedule. • The charge for routine nursery care furnished to a newborn well baby while the mother is an inpatient is a covered medical charge. The requirement that benefits be paid only for a charge that is Medically Necessary does not apply to this benefit. • Benefits for newborn "well babies" are limited to those payable for covered charges incurred for routine nursery care and miscellaneous Hospital services from birth until release from the Hospital.	• Pregnancy-related care is covered for a female Employee or Spouse only. No coverage is provided for delivery charges for a Dependent daughter. Pregnancy of a Dependent daughter will be payable only for treatment of Complications of Pregnancy (including operations for ectopic pregnancy and miscarriage) and for preventive prenatal screenings and other services that are required to be covered under the Affordable Care Act. • Certain prenatal care/maternity related Preventive Care expenses are covered (as listed on the government websites at http://www.hrsa.gov/womensguidelines/ or https://www.healthcare.gov/what-are-my-preventive-care-benefits/ including but not limited to routine prenatal obstetrical office visits, screening for gestational diabetes, HPV testing starting at age 30, rental of breastfeeding equipment and necessary supplies after delivery, and in conjunction with birth, coverage for comprehensive lactation support and counseling by a trained provider during pregnancy and/or in the postpartum period). These services are covered without cost sharing when obtained from In-Network providers. • **Hospital Length of Stay for Childbirth:** Under federal law, group health plans, like this Plan, generally may not 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. However, the Plan may pay for a shorter stay if the attending Physician (e.g., Physician, or Health Care Practitioner), after consultation with the mother, discharges the mother or newborn earlier. The Plan may not from require a Physician or other Health Care Practitioner obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours). • You 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 in the network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining preauthorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. • Routine Nursery care for newborns of Dependent Children is **not** covered.	**Prenatal screenings and other services required by the ACA:** **Breast feeding equipment and supplies:** **Lactation counseling:** Coverage of 100% of In-Network Charges, no Deductible **All other services including ultrasounds and professional delivery fees:** Coverage of 70% of In-Network Allowed Charges (not covered for dependent daughters)	Coverage of 50% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***
Oral, Craniofacial Services • Coverage is provided for accidental injury to Teeth/Jaw	• Treatment of Accidental Injuries to teeth: This Plan covers treatment of certain accidental injuries to the teeth and jaws when all of the following conditions are met: o The accidental injury must have been caused by an extrinsic/external force and not an intrinsic force (such as the force of chewing or biting); and o The dental treatment to be payable is the most cost-effective option that meets acceptable standards of professional dental practice; and o The dental treatment will return the person's teeth to their pre-injury level of health and function. The dental treatment provider is encouraged to seek pre-treatment approval from the Fund Administrator for dental work.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Outpatient (Ambulatory) Surgery Facility/Center • Ambulatory (Outpatient) Surgical Facility/Center (e.g. surgicenter, same day surgery, outpatient surgery). • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an outpatient (Ambulatory) Surgery facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	**Surgery Guidelines:** If two or more surgical procedures are performed at the same time, the covered medical charges will be limited to those incurred for the major procedure plus no more than 50% of those incurred for each lesser procedure that adds significant time or complexity. Coverage includes normal follow-up care and the administration of any local, digital block, or topical anesthesia. Lower benefits may be paid for the administration of other anesthetics if done by the operating or assisting surgeon.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Private Duty Nursing	The charge for the professional services of a Nurse for private duty nursing, but only during a period for which the Fund Administrator validates a Physician's certification that: • the nursing services are Medically Necessary, and • for outpatient nursing, the covered person would be an inpatient at an acute care Hospital or other facility in the absence of those nursing services.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Radiology (X-Ray) (Outpatient) • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***

Reconstructive Services and Breast Reconstruction After Mastectomy
• The Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA) which requires that for any covered individual who is receiving benefits in connection with a mastectomy and who elects breast reconstruction in connection with it, coverage will be provided in a manner determined in consultation with the attending Physician and the patient, including:
  ◦ reconstruction of the breast on which the mastectomy was performed;
  ◦ surgery and reconstruction of the other breast to produce a symmetrical appearance; and
  ◦ prostheses and physical complications for all stages of mastectomy, including lymphedemas.
• Other Reconstructive Surgery covered only if such procedures or treatment are intended to improve bodily function and/or to correct deformity resulting from disease, infection, trauma, or congenital or developmental anomaly that causes a functional defect.
	• See the exclusions related to Cosmetic Services in the Exclusions chapter. Most Cosmetic services are excluded from coverage.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges

Rehabilitation Services (Physical, Occupational & Speech Therapy) • Short term **active**, **progressive** Rehabilitation Services (Occupational, Physical, or Speech Therapy) performed by licensed or duly qualified therapists as ordered by a Physician. • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in an inpatient rehabilitation facility are usually billed separately from the facility fee. See the Physician row of this Schedule for payment parameters.	• Maintenance Rehabilitation services are not covered. • Habilitation services are not covered. • Rehabilitation services are covered only when ordered by a Physician. • Up to 15 outpatient visits for Physical Therapy are covered per course of treatment (unless additional treatments are preauthorized as Medically Necessary).	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Skilled Nursing Facility (SNF) • The professional fees for Physicians & Health Care Practitioners who deliver covered services to patients in a Skilled Nursing Facility or subacute facility are usually billed separately from the facility fee. See the "Physician" row of this Schedule for payment terms.	• Services must be ordered by a Physician.	Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***

Smoking/Tobacco Cessation Benefits
• This benefit can be used to help with nicotine addiction (to help you stop smoking or stop chewing tobacco).
	• Screening for tobacco use; and,
	• For those who use tobacco products, coverage for at least two tobacco cessation attempts per year. Cessation attempt includes coverage for:
	  • Four 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 two 90-day treatment regimens when prescribed by a health care provider without prior authorization. See the Drug section of this Schedule of Benefits.
		Coverage of 100% of In-Network Allowed Charges ,-- no Deductible	No coverage

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 including bone marrow, peripheral stem cells, cornea, heart, heart/lung, intestine, islet tissue, kidney, kidney/pancreas, liver, liver/kidney, lung(s), pancreas, bone, tendons or skin, along with the facility and professional services, FDA approved Drugs, and Medically Necessary equipment and supplies.		Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges
Weight Management The Plan covers screening for obesity for all adults with a body mass index of 30 kg/m^2 or higher and covers: Physician prescribed intensive, multicomponent behavioral counseling interventions.	Certain surgical intervention (such as bariatric surgery) for morbid obesity may be covered if preauthorized by Anthem and determined to be Medically Necessary.	Adult obesity screening and Intensive behavioral counseling: Coverage of 100% of In-Network Allowed Charges, no Deductible All other: Coverage of 70% of In-Network Allowed Charges	Coverage of 50% of Allowed Charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***
Wellness (Preventive) Program Well Child Examinations and Immunizations • The wellness/preventive services payable by this Plan are designed to comply with ACA guidance as outlined to the right. • The Plan pays for childhood immunizations that are FDA approved and in accordance with the CDC recommendations for children in the United States. • If the Plan does not have an In-Network provider/professional qualified or available to provide the preventive services required by the ACA and you must use the services of a non-network provider or professional, claims will be reimbursed without any Participant cost-sharing, in the same manner as if an In-Network provider had been used.	**Covered Services from a Network provider may include:** The wellness/preventive services payable by this Plan are designed to comply with ACA guidance and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures and the Centers for Disease Control and Prevention (CDC). These websites (periodically updated) list the types of payable preventive services, including immunizations: https://www.healthcare.gov/what-are-my-preventive-care-benefits/ with more details at http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.hrsa.gov/womensguidelines/ and http://www.uspreventiveservicestaskforce.org/BrowseRec/Index • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share (e.g. coinsurance and Deductible) for the diagnostic or therapeutic services but not for the preventive services. When a preventive visit turns into a diagnostic or therapeutic service in the same visit, then cost-sharing (e.g. coinsurance and Deductible) will apply to the diagnostic or therapeutic services provided. • Services not covered under the wellness/preventive benefit may be covered under another portion of the medical plan. Additional diagnostic services that are Medically Necessary because of the patient's medical diagnosis are covered, subject to the Plan's Deductibles and Coinsurance and all other Plan provisions. • If an ACA-required preventive service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters. • If there is no network a provider who can provide the ACA required wellness service, then the plan will cover the service when performed by an Out-of-Network provider without cost-sharing. **Covered Services from a Non-Network provider may include:** • Charges for generally accepted tests for routine cancer screening (covered screenings will be based on American Cancer Society recommendations and guidelines). • **Well child care** (up to age 17 years of age) includes the following: o The charge of a Physician for the initial pediatric examination of a newborn performed before the child is released from nursery care. o The charges of a Physician for no more than 18 outpatient visits at about these ages: birth, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 2 years, 3 years, 4 years, 5 years, 6 years, 8 years, 10 years, 12 years, 14 years, and 16 years. • The covered services at each outpatient visit may include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations, and laboratory tests, in keeping with prevailing medical standards. **School/sports exams are not covered.**	Coverage of 100% of In-Network Allowed Charges, no Deductible	Coverage of 50% of Allowed charges

SCHEDULE OF MEDICAL BENEFITS This chart explains the benefits payable by the Medical Plan. All benefits are subject to the Deductible except where noted. *IMPORTANT: Out-of-Network providers are paid according to the Allowed Charge as defined in the Definitions chapter and could result in Balance Billing to you.			
Benefit Description	**Explanations and Limitations of Benefits**	**In-Network**	**Out-of- Network***
Wellness (Preventive) Program: Adult Health Maintenance Examinations (Age 18 & up) • The wellness/preventive services payable by this Plan are designed to comply with ACA guidance as outlined to the right. Certain non-Prescription Drugs required to be covered in compliance with the ACA are available through the Prescription Drug program described below. • If a provider orders lab or x-rays tests in addition to and at the same time as what is covered in accordance with Preventive Care expenses, benefits for the non-Preventive Care related tests will be paid at the Plan payment level for non-wellness/preventive lab and radiology services. • If the Plan does not have an In-Network provider/professional qualified or available to provide the preventive services required by the ACA and you must use the services of a non-network provider or professional, claims will be reimbursed without any Participant cost-sharing, in the same manner as if an In-Network provider had been used.	The wellness/preventive services payable by this Plan are designed to comply with Affordable Care Act guidance and the current recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures, & the Centers for Disease Control and Prevention (CDC). These websites (periodically updated) list the types of payable preventive services (such as immunizations, mammogram, pap smear, colonoscopy with polyp removal): https://www.healthcare.gov/what-are-my-preventive-care-benefits with more details at: http://www.cdc.gov/vaccines/schedules/hcp/index.html, http://www.uspreventiveservicestaskforce.org/BrowseRec/Index; and http://www.hrsa.gov/womensguidelines/index.html • Preventive care expenses for women include well woman office visits, screening for gestational diabetes, BRCA breast cancer gene test, Ages 30-65, screening with pap smear alone every three years, or screening with pap smear and human papillomavirus (HPV) testing every five years, counseling on sexually transmitted infections, annual HIV screening and counseling, no cost for coverage for tamoxifen or raloxifene for women who are at increased risk of breast cancer and low risk for adverse medication effects. • When both preventive services and diagnostic or therapeutic services occur at the same visit, you pay the cost share for the diagnostic or therapeutic services but not for the preventive services. "Preventive services" are those services performed for screening purposes when the individual does not have active signs or symptoms of a condition. The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive (as well as any additional factors the Plan applies in conformance with the ACA). • Condoms are NOT covered.	Coverage of 100% of In-Network Allowed Charges, no Deductible	**Exam for Employee only:** Coverage of 100% of Allowed Charges **Other Charges:** Coverage of 50% of Allowed Charges

REQUIRED PREAUTHORIZATIONS

Purpose of Receiving Advance Approval for Certain Services

The Indemnity Medical Plan requires that you get advance approval for certain services to ensure they are Medically Necessary and covered by the Plan.

Required Preauthorizations

WHAT SERVICES MUST BE PREAUTHORIZED BEFORE SERVICES ARE PROVIDED?

- Hospice Care
- More than 15 visits per course of treatment for chiropractic care or Physical Therapy

Preauthorization does not mean benefits are payable in all cases. Coverage depends on the services that are actually provided, whether you remain eligible in the month that the service is provided, and any other applicable benefit limitations.

Preauthorization is not required for treatment other than Hospice, chiropractic or Physical Therapy HOWEVER, IT IS STRONGLY RECOMMENDED THAT YOU OBTAIN PREAUTHORIZATION BEFORE AN INPATIENT HOSPITALIZATION because any days in the Hospital that are subsequently determined not to have been Medical Necessary will not be paid. We also encourage you to contact TAP prior to receiving any chemical dependency treatment.

However, where an Anthem Blue Cross provider's PPO Network agreement ("Provider agreement") imposes contract terms that the Fund is contractually obligated to comply with, the applicable provision(s) of the Provider agreement shall control how this Plan will cover, process, and pay the claim.

REMINDER: It is YOUR RESPONSIBILITY to ensure that your Physician calls the Fund Administrator to obtain Preauthorization when required.

1. **Advance approval must be obtained before treatment is received, or there are no benefits available.**
2. The caller should be prepared to provide all of the following information: The Fund's name, Employee's name, patient's name, address, and phone number and social security number; Physician's name, and phone number or address; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.
3. **If the Preauthorization review process was not properly followed,** or if there is missing information, the caller will be notified as soon as possible but no later than five calendar days after your request.
4. If additional information is needed, the Fund Administrator will advise the caller.
5. The Fund Administrator will let you and your Physician know whether or not the proposed health care services have been certified as Medically Necessary.
6. **Note that, for a variety of reasons, Preauthorization does not guarantee payment of benefits. For example, if the information submitted during Preauthorization varies from the actual services performed on the date of service, the service performed is not a covered benefit, and/or you are no longer eligible for benefits on the actual date of service.**

Appealing a Preauthorization (Appeals Process)

You may request an appeal of any adverse decision made during the Preauthorization review of benefits (Hospice, chiropractic and Physical Therapy) where Preauthorization is required by the Plan. To appeal a denied claim/bill, see the Claim Filing and Appeal Information chapter of this document beginning on page 60.

Failure to Follow Required Preauthorization Procedures

If you do not follow the Preauthorization requirements for Hospice, chiropractic or Physical Therapy outlined above, no benefits will be paid for that claim.

LIMITATIONS AND PLAN EXCLUSIONS

In addition to any limitations and exclusions described under a specific benefit section of this SPD, there are limitations and exclusions with regard to benefits under the Medical Plan.

GENERAL EXCLUSIONS

- Injuries or conditions caused by or resulting from your commission of an illegal act; provided, however, that this exclusion will not apply if the injury or condition resulted from an act of domestic violence or an underlying health factor, to the extent that treatment for the injury or condition would otherwise be covered.
- Injuries or conditions that are intentionally self-inflicted unless due to a mental or physical health condition.
- Injuries or conditions resulting from or arises out of any past or present employment or occupation for compensation or profit or covered by any workers' compensation or occupational disease law.
- Injuries or conditions that resulted from an act of war, declared or undeclared, including armed aggression.
- Charges for treatment of accidental bodily injury or sickness that occurs while in the armed services and determined by the Secretary of Veterans Affairs to be service connected.
- Charges for treatment of Illness or injury or for dental services or supplies that are not reasonably necessary for medical or dental health.
- Charges for treatment of an Illness or injury that are in excess of the Allowed Charges or are in excess of charges that would have been made for this care and treatment in the absence of benefits provided by the Plan. The Plan will not pay any expenses the Participant is not obligated to pay, such as expenses incurred under HMO coverage for which no charge would otherwise be made to the patient.
- Charges for which you are not personally obligated to pay the charge (or part of a charge) for the services, or you would not have been billed for the charge if you were not otherwise covered by the Plan (e.g. expenses covered by an HMO for which no charge would otherwise be payable).
- Charges for services that were provided by a person who ordinarily lives in your home or by your Spouse, child, parent, or sibling or your Spouse's child, parent or sibling,
- Services or supplies provided by or paid for a federal government agency or by any state or political subdivision, except (1) where there is an unconditional legal obligation to pay for charges without regard to the existence of any insurance or Employee benefit plan; and (2) The Veterans Administration or a military Hospital will be reimbursed in accordance with the Plan for charges incurred by a covered person for services or supplies which are unrelated to military service.
- Services or supplies furnished for the treatment of a condition for which the Plan Participant is not under the care of a Doctor.

EXCLUSIONS FOR THE MEDICAL PLAN

- Charges for artificial insemination, in-vitro fertilization, hormone therapy or any other treatment of infertility.
- Charges for the following allergy tests: cytotoxic, sublingual and provocative neutralization testing.

- Charges incurred for a treatment that is not generally accepted by the medical profession, or is listed as Experimental (as defined on page 107), unless coverage is required by the Affordable Care Act.
- Any service or supply that is not incurred as the result of a disease or injury or is not Medically Necessary, except as specifically provided, or as required by the Affordable Care Act.
- Any service or supply that is not prescribed by a Physician or by a Healthcare Practitioner who is practicing within the scope of his license.
- Any Drugs or medicines, other than those furnished to a covered person who is an inpatient or Medically Necessary Drugs administered in a Physician's office. Please see page 38 for information regarding your Prescription Drug plan.
- Custodial care, regardless of who prescribes or renders such care.
- Eye refractions, orthoptics (vision therapy), glasses, contact lenses, or the fitting of glasses or contact lenses, except for the first pair of glasses or first pair of lenses for use after cataract surgery. Please note that routine vision care is covered under your vision plan (see page 43).
- Reversal of sterilization.
- Any procedure performed mainly to improve the appearance of the covered person, unless it is reconstructive surgery following a mastectomy or it is for Cosmetic surgery for repair of damage sustained in an Accident, and the charges are incurred within one year from the date of the Accident or within a reasonable time thereafter applied without respect to when the individual was first enrolled in the plan.
- Dental services to include any service or supply to diagnose, treat, repair, or replace the teeth, gums, or supporting structure of the teeth, or repair of damage to teeth unless the damage is sustained in an Accident and the charges are incurred within 1 year from the date of the Accident applied without respect to when the individual is enrolled in the plan. **Note:** This exclusion will not apply to facility or anesthesia charges incurred for a child under age 7 or for a person of any age who is severely disabled or whose health would be at serious risk without the use of general anesthesia for purposes of dental treatment.
- Charges for care in a rest home or convalescent facility.
- Any treatment related to sexual dysfunction not explicitly covered elsewhere.
- Environmental equipment.
- Radial Keratotomy, Lasik or any procedure to reduce or replace need for glasses or contact lenses.
- Repair of Durable Medical Equipment or prosthesis (replacement may be covered in limited circumstances).
- Expenses related to obesity, diet control or counseling, weight loss or physical conditioning even if ordered by a Physician except:
    - ✓ certain treatment of morbid obesity if preauthorized by Anthem; and
    - ✓ for obesity screening for adults, diabetes self-management training program and intensive multicomponent behavioral counseling for weight management for obese adults as described in this SPD and any screenings otherwise required by the Affordable Care Act.
- Expenses associated with a Dependent Child's pregnancy and delivery (including elective abortion), except for complications related to pregnancy. This exclusion of maternity care for a pregnant Dependent Child does not apply to certain prenatal screenings that are required to be covered under the Affordable Care Act.

- A private Hospital room that is not Medically Necessary.
- Chelation therapy except for acute arsenic, gold, mercury or lead poisoning.
- Charges for products, supplies, or supplements related to alternative medicine (except acupuncture and chiropractic services are covered), including holism, homeopathic, naturopathic, orthomolecular, massage therapy and any other kind of similar alternative medicine treatment.
- Habilitation treatment.
- Long-term care

Exclusions Applicable to Specific Medical Services and Supplies

A. Allergy/Alternative/Complementary Health Care Services Exclusions

1. Charges for the following allergy tests: cytotoxic, sublingual and provocative neutralization testing.
2. Charges for any services related to alternative medicine, including holism, homeopathic treatment, orthomolecular services, massage therapy and any other kind of similar treatment

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

1. Expenses for **replacement of lost, missing, or stolen**, **duplicate or personalized** Corrective Appliances, Orthotic Devices, Prosthetic Appliances, or Durable Medical Equipment.
2. Air conditioners, air purifiers, heat lamps, heating pads, bed boards, orthopedic shoes, gravity traction devices, exercise bicycles, weight lifting equipment, and specially equipped vans. In addition, repair of a prosthetic device or of Durable Medical Equipment (except where explicitly noted in this SPD) is not covered. This is only a partial list of the types of equipment and devices the Fund does **not** consider Durable Medical Equipment and is provided for illustrative purposes.
3. Expenses for Corrective Appliances and Durable Medical Equipment to the extent they **exceed the cost of standard models** of such appliances or equipment.
4. Orthopedic shoes.

C. Cosmetic Services Exclusions

1. Any procedure performed mainly to improve the appearance of the covered person, unless it is reconstructive surgery following a mastectomy or it is for Cosmetic surgery for repair of damage sustained in an Accident and the charges are incurred within one year from the date of the Accident or within a reasonable time thereafter (applied without respect to when the individual is enrolled in the plan).

D. Custodial Care Exclusions

Expenses for Custodial Care as defined in the Definitions chapter of this document, regardless of where they are provided, including, without limitation, adult day care, child day care, services of a homemaker, or personal care, sitter/companion service.

F. Fertility and Infertility Services Exclusions

Services to induce pregnancy and complications thereof, including, but not limited to services, Prescription Drugs, procedures or devices to achieve fertility; in vitro fertilization; low tubal transfer; artificial insemination; embryo transfer; gamete transfer; zygote transfer; surrogate expenses (surrogate refers to an arrangement for a woman to carry and give birth to a child who will be raised, and usually legally adopted, by others and often includes invitro fertilization, the implantation of a fertilized egg for the purpose of carrying the fetus to term for another woman) including expenses for and related to the pregnancy, delivery fees and complications for the woman who is the surrogate; donor

egg/semen or other fees; cryostorage of egg/sperm; ovarian transplant; infertility donor expenses; fetal implants; fetal reduction services; surgical impregnation procedures; and reversal of sterilization procedures.

G. Foot Care/Hand Care Exclusions

Expenses for **routine foot care**, (routine foot care includes but is not limited to hygienic cleaning of the feet with trimming of toenails, removal or reduction of corns and callouses, removal of thick/cracked foot skin, Preventive Care with assessment of pulses, skin condition and sensation).

H. Hearing Care Exclusions

1. Expenses for and related to the purchase, servicing, fitting and/or repair of hearing aid devices.
2. Expenses for and related to repairs to hearing aids including replacement parts, lost, stolen or missing hearing aids, hearing aid batteries and other hearing aid accessories.

I. Home Health Care Exclusions

1. Expenses under a Home Health Care program for services that are provided by someone who ordinarily lives in the patient's home or is a parent, Spouse, sibling by birth or marriage, or child of the patient; or when the patient is not under the continuing care of a Physician.
2. Expenses for a homemaker, Custodial Care, childcare, adult care or personal care attendant, except as provided under the Plan's Hospice coverage.

J. Maternity/Family Planning/Contraceptive Exclusions

1. Expenses related to non-prescription contraceptive Drugs and devices for males, such as condoms
2. Expenses related to the **maternity care and delivery expenses associated with a pregnant Dependent Child.** This exclusion of maternity care for a pregnant Dependent Child does not apply to certain prenatal screenings required by the Affordable Care Act, but the exclusion does apply to maternity services such as ultrasounds and delivery expenses.

K. Rehabilitation Therapy Exclusions (Inpatient or Outpatient)

Expenses for Habilitation services (to help individuals attain certain functions that they never have acquired) including treatment of delays in childhood speech and physical development, even if the delay in development is a direct result of an injury, surgery or as a result of a treatment that is the type that is covered by this Plan.

L. Weight Management and Physical Fitness Exclusions

Expenses for memberships in or visits to health clubs, exercise programs, gymnasiums, and/or any other facility for physical fitness programs, including exercise equipment, fitness instructors, work hardening and/or weight training services or exercise/activity/health monitoring/tracking devices, or software applications including smartwatches/jewelry and wireless or wearable sensors/trackers.

SUBSTANCE ABUSE

The benefits described in this chapter are available to you only if you are enrolled in the Indemnity Medical Plan. If you elected Kaiser HMO coverage, your benefits for treatment of alcoholism and chemical dependency are provided through Kaiser.

Treatment of alcoholism and/or other chemical dependencies under the Plan is provided through the Teamsters Assistance Program of Northern California (TAP).

The following chart is intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the chart.

Summary of Alcoholism and Chemical Dependency Benefits		
Covered Services	**TAP Provider ***	**Non-TAP Provider**
Inpatient detoxification (Medical)	Coverage of 100% of Allowed Charges, no Deductible	Coverage of 100% of Allowed Charges, no Deductible
Inpatient rehabilitative treatment at an approved facility (TAP)	First admission: Coverage of 100% of Allowed Charges, no Deductible Second admission: 70% after Deductible	Coverage of 50% of Allowed Charges
Outpatient rehabilitative treatment	Coverage of 80% of Allowed Charges, no Deductible	Coverage of 50% of Allowed Charges

*** Please note that if a Participant utilizes an Anthem Blue Cross In-Network facility that is NOT a TAP facility for treatment of chemical dependency, the Fund will allow the contracted rate but it is payable at the Out-of-Network coinsurance.**

How Your TAP Coverage Works

The plan provides for three types of treatment: inpatient detox, inpatient rehabilitative care, and outpatient treatment.

Required Pre-Authorizations and Other Conditions of Coverage

Preauthorization is not required, but we strongly recommend obtaining Preauthorization because any days that are subsequently determined to be not Medically Necessary will be denied.

To request pre-authorization or notify TAP of an admission for detox, call 510-562-3600. All communication with TAP is strictly confidential.

Note: Requests for required pre-authorizations are considered "pre-service claims" (*or "urgent care claims," if a decision needs to be made on an expedited basis*). If you disagree with the decision made on your request for pre-authorization, you may file an appeal. See the information on the applicable type of claim in *"Claims and Appeals Procedures"* beginning on page 60.

Providers You May Use

To receive the highest level of benefits, we strongly recommend that you contact TAP before receiving any treatment (inpatient or outpatient). Any days or treatment determined not to be Medically Necessary will be denied. The TAP counselor will refer you to an approved facility or provider when you call for pre-authorization.

For inpatient detox, you may use any licensed acute-care facility. Remember, however, that costs will be lower if you use a Blue Cross Prudent Buyer facility. Call the Fund Administrator or go online to www.bluecrossca.com to find a Prudent Buyer facility.

Exclusions from Coverage

The Fund will not pay benefits for any treatment excluded under the Plan's "General Limitations and Exclusions" beginning on page 32.

PRESCRIPTION DRUG COVERAGE

If you are enrolled in the Indemnity Medical Plan option, your prescription drug coverage is provided under the program described in this Chapter.

If you have your medical coverage through Kaiser HMO, your prescription drug coverage is provided through Kaiser.

Your Plan provides benefits for medically necessary drugs you purchase at retail pharmacies or through the plan's mail-order service. The Fund has contracted with OptumRx to administer these benefits.

How the Plan Works

If you use a participating retail pharmacy or the mail-order service, you will pay only your copay for your prescription to be filled. **There are no benefits available for prescriptions purchased at a Non-Participating pharmacy.**

Participating Pharmacy List

A list of participating pharmacies is available at no cost from the Fund Administrator. You can also call OptumRx at 1-800-797-9791 or go online (www.optumrx.com) to find a participating pharmacy.

Prescription drug benefits are separate from your medical benefits, so they are not subject to any medical plan deductible.

(***Note:*** *The benefits described in this chapter do not apply to prescription drugs furnished to you while you are in the hospital, which are covered under the Medical Plan.*)

The following chart summarized your copays for prescription drugs:

Summary of Prescription Drug Benefits

Prescription Drug	Network Pharmacy	Non-Network Pharmacy **
Out-of-Pocket Maximum for drugs purchased at an In-Network pharmacy	$3,250 individual; $7,500 family	Unlimited
In-Network Retail Pharmacy (up to a 30-day supply):	***Generic:*** $10 copay ***Preferred Brand:*** $20 copay ***Non-Preferred Brand:*** $40 copay	Not covered
Mail Order Service (up to a 100-day supply) *	All copays 2 times the retail copay	Not covered
Specialty Drugs (must be filled through BriovaRx)	Specialty Drugs: same copay as noted above under generic and brand drugs	Not covered
Certain Preventive Care drugs as required by ACA, Female contraceptives, tobacco cessation drugs and generic tamoxifen (with a prescription)	No charge	Not covered

* Prescriptions will be covered for no more than a 100-day supply.

** If you purchase a covered prescription drug at a Non-Network pharmacy, you will need to pay 100% of the cost to the pharmacy and submit a claim to the Fund for reimbursement.

Preventive Care Drugs Mandated under the ACA

The following preventive care drugs are payable by Fund, **at no charge when prescribed by a Physician or health care practitioner and purchased at a network retail pharmacy location**, in accordance with ACA guidance and the US Preventive Service Task Force (USPSTF) A and B recommendations. For a preventive care drug to be covered by the Plan, the drug must be:

1. obtained at a **participating network retail pharmacy** and
2. presented to the **pharmacist with a prescription for the preventive care drug** from your Physician or health care practitioner.

Please note: while these preventive care drugs require a prescription in order to be reimbursed by the Fund, insulin is payable by the Fund without a prescription.

- Generic aspirin with a prescription for Participants over 44 years of age: One bottle of 100 tablets every 3 months. Also, low dose OTC aspirin are covered for women after 12 weeks of gestation who are at high risk for preeclampsia and low-dose aspirin use for the primary prevention of cardiovascular disease and colorectal cancer in adults aged 50 to 59 years who have a 10% or greater 10-year cardiovascular risk, are not at increased risk for bleeding, have a life expectancy of at least 10 years, and are willing to take low-dose aspirin daily for at least 10 years.
- Generic folic acid supplements (one bottle of 100 tablets every 3 months).
- Generic vitamin D supplements (one bottle of 100 tablets every 3 months for adults over age 65 who are at risk for falling).
- Generic oral fluoride supplements for ages 6 months to 6 years when recommended because primary water source is deficient in fluoride.
- FDA-approved Contraceptives for females, such as birth control pills, spermicidal products and sponges.
- Preparation "prep" products for a colon cancer-screening test.
- Tobacco cessation drugs (two 90-day treatment regimens per calendar year).
- Statin preventive medication for Adults ages 40-75 years with: no history of cardiovascular disease (CVD), 1 or more CVD risk factors, and a calculated 10-year CVD event risk of 10% or greater.
- Risk-reducing medications (such as tamoxifene or raloxifene) for women at increased risk for breast cancer and at low risk for adverse medication effects.

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

Preauthorization and other Clinical Programs

OptumRx has implemented the following programs that are designed to protect both you and the Fund:

- **Prior Authorization:** OptumRx requires prior authorization for certain medications before they are covered to promote safe and effective medication use in addition to helping keep pharmacy plan costs in check.
- **Step Therapy:** Requires members to try preferred medications as the initial step in their treatment before certain non-preferred medications are covered.
- **Quantity Limits:** Helps ensure safe and appropriate dosing and avoid dangerous drug interactions through established guidelines and coverage levels.
- **Opioid Risk Management:** Narcotic utilization management and quantity (morphine equivalent dose based) and day supply limits on short acting opioids. As opioid dependence

can start in just a few days, it's important to stop opioid abuse before it starts. That means limiting the dose and duration at the very first fill. OtpumRx has developed a utilization management program that is aligned with Centers for Disease Control and Prevention (CDC) prescribing guidelines.

- **High-cost product compounds** may be subject to prior authorization (PA).
- **BriovaRx Specialty Pharmacy and Clinical Management Program for Specialty Pharmacy Users:** OptumRx / BriovaRx Specialty Pharmacy is 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 must be filled using the OptumRx/BriovaRx Specialty Mail Order Pharmacy and will be limited to a 30-day supply per fill. Shipping is at no charge to you for your 30-day supply. Participants taking HIV/AIDS medications can opt out of this program by calling 1-866-803-8570.

  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 1-855-4BRIOVA or go online to BriovaRx.com.

  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 BriovaRx.com for additional information.

Mandatory Maintenance Mail Service Program

All plan participants taking a prescribed Maintenance Medication for a period longer than 90 days must use the OtpumRx mail order pharmacy. AFTER 90 DAYS, YOUR PRESCRIPTION WILL NOT BE COVERED UNLESS YOU USE THE MAIL ORDER PROGRAM. **If you fill your maintenance medication prescription through a retail pharmacy after the first 90 days, it will not be covered under your Plan.** Once you have filled a prescription for six months through the mail order service, you may go back to filling the prescription through a retail pharmacy.

Pre-addressed envelopes for using the OptumRx mail-order service are available from the Fund Administrator. This service offers a convenient way to fill prescriptions for drugs you will be taking on a longer-term basis.

The first time you have a prescription filled through the mail-order service, you will be asked to complete a health history profile for your protection. When your prescription is sent to you, the package will include a form and envelope for ordering refills. You may also order refills by phone (800-562-6223) or online at www.optumrx.com.

Medicare Part D Creditable Coverage

The prescription drug coverage offered by the Fund is comparable to prescription drug plans offered under Medicare "Part D" (Medicare prescription drug coverage). The federal Centers for Medicare and Medicaid Services (CMS) will consider your coverage under the Fund to be "creditable," which means that, on average, the Fund will pay as much or more for your prescription drug coverage than Medicare would pay if you enrolled in Part D. *Therefore, you should **not** enroll in Medicare Part D coverage if you have prescription drug coverage under the Bay Area Delivery Drivers Security Fund*.

Medicare expects you to enroll in a Part D drug plan as soon as you become eligible, and charges higher premiums to late enrollees, *unless you are already covered by creditable prescription drug coverage* like your coverage under the Bay Area Delivery Drivers Security Fund. Because your

coverage under this plan is deemed "creditable," by Medicare for purposes of Part D, if you decide to enroll in Part D in the future – because, for example, your Fund coverage terminates – you will not be penalized for late enrollment in Part D. If your Fund coverage ends, you will have 63 days to enroll in another Medicare Part D drug plan without incurring a late enrollment premium.

Covered Prescription Drugs

There is no "formulary" or list of covered drugs. Generally, a drug will be covered if it has been approved by the U.S. Food and Drug Administration (FDA) and not prescribed for treatment that is excluded by the Plan. The drugs in the following list are examples of drugs typically covered by the Plan. If you have a question regarding whether a particular drug is covered, you may call the OptumRx at 1-800-797-9791.

Benefits are payable for the following:

- FDA-approved contraceptives for women are covered if submitted with a Physician prescription and filled at an In-Network or Mail Order location. Generic contraceptives will be covered at 100% with no cost-sharing (or a brand prescription contraceptive only if a generic contraceptive is unavailable or medically inappropriate as determined by the patient's Physician).
- Pharmaceuticals requiring a written prescription and dispensed by a licensed pharmacist (or by a hospital pharmacy during a period not involving hospital confinement for the treatment of an illness or injury).
- Compounded dermatological preparations such as ointments and lotions that must be prepared by a pharmacist according to your Physician's prescription. This excludes bulk chemicals if they are not recommended by the FDA for compound use, have more affordable FDA-approved alternatives on the market or have questionable clinical value and certain pre-packaged formulations from coverage.
- Therapeutic vitamins, cough mixture, elixir terpin hydrate, N.F., antacids, and eye and ear medications prescribed by your Physician to be used in the treatment of a specific illness.
- Insulin and diabetic supplies.
- Epinephrine, U.S.P., ephedrine sulfate – 25 mg. (3/8 gr.), ferrous sulfate, U.S.P.
- Injectable drugs only if purchased exclusively through OptumRx "Specialty Drug" mail order (See "Mail Order Service" above).

  Note: However, the following Injectable drugs are exempt from the mail order requirement: (1) Injectables routinely administered at a doctor's office or hospital (*e.g.*, chemotherapy) covered under the Medical Plan (or Kaiser); and (2) Injectables that must be taken immediately to address life-threatening circumstances. For this purpose, "life threatening' circumstances" is not intended to apply to any medication required to treat a serious medical condition but only to circumstances where the symptoms presented make it necessary to administer the Injectable immediately.

Exclusions from Coverage

No benefits will be paid for the following:

1. Patent or proprietary medicines not requiring a prescription.
2. Immunization agents, biological sera, blood or blood plasma, or medication prescribed for parenteral use or administration (except insulin).
3. Appliances and other non-drug items.
4. Multiple and non-therapeutic vitamins (except as otherwise required under the Affordable Care Act), cosmetics, dietary supplements (except as otherwise required under the Affordable Care Act), or health and beauty aids.

5. Drugs for which reimbursement is provided or paid for by any other group plan or federal, state, county, or municipal government program.
6. Any single filling or refilling of a prescription for drugs taken in accordance with the doctor's directions in excess of a 100-day period unless a prior written agreement has been reached with the Fund.
7. Prescription charges due to occupational injuries or due to sickness covered by Workers' Compensation laws or similar legislation.
8. Drugs not approved by the FDA.
9. Prescription drug claims filed more than 90 days after the prescription is filled.
10. Any charges excluded under the Plan's "General Limitations and Exclusions"
11. Cosmetic, health or beauty aids; and
12. Fertility Drugs (oral and injectable forms). Conditional approval for progesterone supplement in pregnancy, subject to medical review.
13. Select bulk chemicals and excipients that are not approved by the FDA, have questionable clinical value or excessive costs, and/or conflict with benefit limits. These types of chemical or excipient exclusions often include products dispensed for cosmetic purposes or in lieu of over-the-counter alternatives

VISION BENEFITS

Vision Plan benefits are treated as a standalone (or "excepted") benefit under HIPAA and the Affordable Care Act. However, while vision benefits are generally exempt from the PPACA, the Plan covers your children up to age 26.

Eligibility

Plan Participants and their covered Dependents are eligible for Vision benefits effective when you meet the standard eligibility requirements described beginning on page 5 of this SPD.

Benefits

Your vision benefits cover you and your enrolled Dependents for regular examinations and for lenses and frames necessary to correct your vision. Vision benefits are provided through the Vision Service Plan (VSP) network of vision providers.

The following chart is intended to provide a convenient quick-reference guide to your benefits. More detailed information, including conditions for payment of different benefits, follows the Summary of Vision Benefits.

Summary of Vision Benefits		
Benefits for Covered Services and Supplies		
Item	**VSP Provider**	**Non-VSP Provider**
Exam (once every 12 months)	Covered in full	Plan reimburses up to $50
Frames (once every 24 months, if needed)	Covered up to $150	Plan reimburses up to $70
Eyeglass lenses (once every 12 months, if needed):		
• **Single vision**	Covered in full	Plan reimburses up to $50 per pair
• **Bifocal**	Covered in full	Plan reimburses up to $75 per pair
• **Trifocal**	Covered in full	Plan reimburses up to $100 per pair
• **Lenticular**	Covered in full	Plan reimburses up to $125 per pair
Contact lenses (once every 12 months, in lieu of all other lens and frame benefits)		
• **Visually necessary (must be pre-authorized by VSP)**	Covered in full	Plan reimburses up to $210 for professional fees and materials

Summary of Vision Benefits		
Benefits for Covered Services and Supplies		
Item	**VSP Provider**	**Non-VSP Provider**
• **Elective**	$130 allowance for contact lens material only; fitting and evaluation copay (up to $60) does not apply.	Plan reimburses up to $105 for professional fees and materials
Low vision benefit	*See the separate chart in "Low Vision Benefit" later in this chapter*.	

How the Plan Works

VSP Providers

As noted above, vision care services are provided through an arrangement with Vision Service Plan (VSP). You can receive a higher level of benefits by obtaining services and supplies from a VSP provider.

Steps for using a VSP provider are as follows:

- Call any VSP participating vision provider to make an appointment (you do not need to obtain a benefit form from VSP first). Identify yourself as a VSP member and provide your VSP member identification number and the name of the group plan ("Bay Area Delivery Drivers Security Fund").
- If you need assistance locating a VSP participating provider, call VSP at 800-877-7195 or log on to the VSP website at www.vsp.com and use the "Find a Doctor" feature.
- After you have scheduled an appointment, the VSP participating provider will contact VSP to verify your eligibility and plan coverage.
- When you go for your visit, pay the provider any amount due if you have incurred charges that are not covered in full. VSP will pay the provider directly for the balance of the charges.

Non-VSP Providers

You may choose to use a non-VSP provider instead of a VSP provider (any licensed optometrist, ophthalmologist, or dispensing optician). However, plan benefits will then be limited to the applicable reimbursement allowances.

If you use a non-VSP provider, you will need to pay the provider in full at the time of your visit, then file a claim for reimbursement with VSP.

Covered Services and Supplies

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

Benefits for frames and lenses include such professional services as prescribing and ordering proper lenses, assisting in the selection of frames, verifying the accuracy of the finished lenses, and proper fitting and adjustment of glasses.

Exams

The Plan covers an examination of visual functions once every 12 months, including the prescription of corrective eyewear where indicated.

If you use a VSP provider, the Plan pays the full cost. If you use a non-VSP provider, the Fund will reimburse you for the cost of the exam up to $50.

Frames

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

See also "Optional Extras" later in this chapter for information on frames whose cost exceeds the Plan allowance.

Eyeglass Lenses

The Plan will cover new lenses once every 12 months if a prescription change is warranted.

See "Optional Extras" later in this chapter for information on options such as blended or progressive multifocal lenses or UV protection.

Contact Lenses

Contact lenses are available once every 12 months in lieu of all other lens and frame benefits. Once you obtain contact lenses under the Plan, you will not be eligible for other lenses for 12 months or new frames for 24 months.

Necessary

Necessary Contact Lenses are a Plan Benefit when specific benefit criteria are satisfied and when prescribed by the Member's Doctor or Non-Member Provider. Prior review and approval by VSP are not required for the member to be eligible for Necessary Contact Lenses.

Elective

Contact lenses not at the necessary level will be considered elective. The Plan will cover up to $130 of the costs for the elective contact lens materials if you use a VSP. The fitting and evaluation fee will be discounted by 15% and capped at $60. If you choose to go to a non-VSP provider, the plan will reimburse you up to $105 for elective contact lens materials.

Optional Extras

Your vision benefits are designed to cover visual needs rather than Cosmetic materials. If you select any of the following extras, the Plan will pay the basic cost of the allowed lenses and frames and you will pay the additional costs for these options:

- a frame that costs more than the VSP plan allowance
- blended lenses
- oversize lenses
- photochromic lenses or tinted lenses, except Pink #1 and Pink #2
- progressive multifocal lenses
- coating of the lens or lenses
- laminating of the lens or lenses
- Cosmetic lenses
- optional Cosmetic processes
- UV (ultraviolet) protected lenses
- low vision care other than that specified under "Low Vision Benefit" later in this chapter.

Additional Discounts

If you would like an additional pair of glasses or would like to be fitted for contact lenses in addition to glasses, you can take advantage of the Plan's additional discounts program described below. Discounts are available only if you use VSP providers.

Additional Pairs of Eyeglasses

You will be entitled to a discount of 20% toward the purchase of additional complete pairs of prescription glasses (lenses, lens options, and frames) from a VSP provider. "Additional pair" means any complete pair of prescription glasses purchased beyond the benefit frequency allowed under the Plan.

Professional Services for Contact Lenses

You will also be entitled to a discount of 15% on professional fees for elective contact lens evaluations and fittings. To receive this discount, you must receive these services from the VSP doctor who performed your covered eye examination and you must receive them within 12 months of when you had the exam. Discounts are applied to the doctor's Allowed Charge for such services.

Contact lens **materials** will be provided at the doctor's Allowed Charge, with no discount.

Low Vision Benefit

If you have severe visual problems that are not correctable with regular lenses, you may be eligible for supplementary testing and supplemental care aids under the Plan's low vision benefit.

The low vision benefit is summarized in the chart below.

Low Vision Benefit		
General Benefit Features		
Maximum Benefit	$1,000 every 2 years	
Copayment	25% of VSP provider charges for supplemental care aids	
Benefits for Covered Services and Supplies		
Item	**VSP Provider**	**Non-VSP Provider**
Supplementary testing	Covered in full	Plan reimburses up to $125
Supplemental care aids	Plan covers 75% of cost	Plan reimburses up to 75% of what VSP provider would charge

Supplementary testing means complete low vision analysis and diagnosis with a comprehensive examination of visual functions, including the prescription of corrective eyewear or vision aids where indicated. Supplemental care aids include subsequent low vision aids as visually necessary or appropriate.

If you use a non-VSP provider, you will be responsible for any supplementary testing charges over the $125 reimbursement allowance. Your reimbursement for supplemental care aids will be limited to 75% of what VSP would pay a VSP provider. You will be responsible for your copayment (the other 25% of what would be due a VSP provider), plus any amount beyond what a VSP provider would charge for supplemental care aids.

Exclusions from Vision Plan Coverage

In addition to any limitations and exclusions described elsewhere in this SPD, there are limitations and exclusions with regard to Vision benefits. No benefits will be paid for professional services or materials connected with the following:

- orthoptics or vision training and any associated supplemental testing.
- plano lenses (less than a +.38 diopter power).
- two pairs of glasses in lieu of bifocals.
- replacement of lenses and frames furnished under this Plan that 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.
- the additional costs associated with the items listed under "Optional Extras."
- services and/or materials not indicated in this chapter as covered Plan benefits.
- any service or supply excluded under the plans "Medical Plan Exclusions."

DENTAL BENEFITS

Dental plan benefits are treated as a standalone (or excepted) benefit under HIPAA and the Affordable Care Act. However, while dental benefits are generally exempt from the Affordable Care Act's requirements, the Plan covers children up to age 26 and will provide pediatric dental care with no annual maximums to individuals up to 19 years of age.

Eligibility

Plan Participants and their covered Dependents are eligible for Dental benefits effective on the date you meet the eligibility requirements described above on page 5.

Opting Out of Dental Coverage

You and your covered Dependents can choose to "opt out" of the self-funded dental benefits on an annual basis. However, neither your Employer's monthly Contribution for your health coverage nor your share of the monthly Contribution will be reduced if you disenroll. You may obtain a disenrollment form from the Fund Administrator. If you decline dental coverage you may re-enroll for such coverage 12 months later by contacting the Fund Administrator. The Plan permits changes to enrollment in dental benefits once each 12 months.

Dental Network

Network providers (licensed dentists and dental hygienists) have a contract with Premier Access network to provide discounted fees to you for services covered under this dental plan. By using the services of a network provider, both you and the Plan pay less. A current list of network dental providers is available free of charge when you contact Premier Access at the telephone number listed on the Quick Reference Chart in the front of this document or by visiting www.premierlife.com. Simply click on the "find a Dentist" button at the top of the page, and choose "Commercial Plans – Dental PPO" selection on the "Select Plan" dropdown menu.

Services may be received from any licensed dental provider; however, this Plan will pay at the Non-Network benefit level. The itemized bill reflecting the Non-Network provider's fees must be submitted to the Fund Administrator for reimbursement. You will be reimbursed according to the Allowed Charge. Non-Network provider services may cost you more than if those same services were obtained from a network provider. Non-Network Providers may bill the Plan participant for any balance that may be due in addition to the Allowed Charge amount payable by the Plan, also called balance billing. **Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or deductibles) that exceed the Plan's payment for a covered service.** You can avoid balance billing by using Network providers.

You are covered for expenses you incur for most, but not all, dental services and supplies provided by a Dental Care Provider as defined in the Definitions chapter of this document that are determined by the Plan Administrator or its designee to be **"Medically Necessary,"** but only to the extent that:

- the Plan Administrator or its designee determines that the services are the most cost-effective ones that meet acceptable standards of professional dental practice and would produce a satisfactory result; **and**
- services are not **Experimental or investigational; and**
- **services or supplies are not excluded** from coverage (as provided in the Dental Exclusions chapter of this document); and
- **services or supplies are not in excess** of a Maximum Plan Benefit as shown in this chapter; and
- the charges for dental services are **"**Allowed Charge**."** See the Definitions chapter under "Allowed Charge."

The Plan will pay the percentage of covered charges shown in the chart below, subject to the following benefit maximums:

- a calendar-year maximum (meaning the most the Plan will pay per year) on benefits for services other than orthodontia, and
- a lifetime maximum on benefits for orthodontia.

Summary of Dental Benefits	
General Plan Features	
Calendar-year Deductible (applies to ALL dental services including orthodontia)	$50 per Individual
Annual Maximum	$5,000 per Individual (does not apply to children under age 19)
Lifetime Maximum Orthodontia	$2,000 per Individual
Benefits for Covered Services	
Diagnostic and Preventive Benefits	
Diagnostic: • **Oral examinations** • **X-rays** • **Diagnostic models** • **Emergency palliative treatment** • **Specialist consultation**	Plan pays 90% of covered charges
Preventive: • **Prophylaxis (cleaning) (twice in a Calendar Year)** • **Fluoride treatment (for children to age 18 only) (twice in a Calendar Year)**	Plan pays 90% of covered charges
Basic Benefits	
• **Fillings** • **Space maintainers** • **Sealants on permanent first and second molars for Dependent Children** • **Oral surgery** • **Root canals** • **Periodontics (treatment of gums and bones supporting teeth)**	Plan pays 70% of covered charges
Major Restorative Benefits	
• **Crowns and cast restorations**	Plan pays 70% of covered charges
Prosthodontic Benefits	
• **Bridges** • **Dentures**	Plan pays 70% of covered charges

Summary of Dental Benefits	
Orthodontic Benefits	
Orthodontia Benefits for orthodontia will be extended after eligibility expires for expenses incurred for a course of treatment begun before eligibility terminated. This extension will end 6 months from your loss of coverage or, if earlier, the date you are eligible for another plan of coverage or the date the plan is terminated.	Plan pays 70% of covered charges

Deductibles

Each Calendar Year, you are responsible for paying all your Eligible Dental Expenses until you satisfy the annual Deductible. Then, the Plan begins to pay benefits. Please note: the annual Deductible applies to all dental services (including orthodontia).

Coinsurance

Coinsurance is how you and the Plan will split the cost of certain covered dental expenses, after the Deductible is met. Once you've met your annual Deductible, the Plan pays a percentage of the Eligible Dental Expenses, and you are responsible for paying the rest. The applicable percentage paid by the Plan is shown in the Schedule of Dental Benefits. The part you pay is called "Coinsurance".

Pretreatment Estimate (Predetermination of Benefits)

Whenever you expect that your dental expenses for a course of treatment will be more than $500, you may use the voluntary pretreatment estimate procedure. This procedure lets you know how much you will have to pay before you begin treatment.

To obtain a pretreatment estimate, you and your Dentist should complete the regular dental claim form, available from and to be sent to Premier Access Insurance Company indicating the type of work to be performed along with pertinent x-rays, diagnostic materials and the estimated cost. The Fund Administrator can then advise you and your Dentist ahead of time whether the proposed treatment is covered under the Plan and, if so, the amount that will be payable or such treatment. If there is a change in the treatment plan, a revised plan should be submitted.

Predetermination of benefits is not a guarantee of payment. Payment is based on the services actually delivered and the coverage in force at the time services are completed.

Dental Exclusions

In addition to any limitations and exclusions described under a benefit section of this SPD, there are limitations and exclusions with regard to Dental benefits described below.

The following Diagnostic and Preventive services are not covered:

- Cleanings where gross residual calculus remains.
- X-rays that are diagnostically unacceptable.
- Sealants on previously restored teeth unless the restoration was to the lingual or buccal surfaces only.
- Fluoride treatment for individuals age 18 or older—and fluoride treatment more than twice in a Calendar Year for individuals under age 18.
- Dietary planning for control of dental caries.
- Separate instruction in oral hygiene and "plaque control."

- Space maintainers where first permanent and second deciduous molars are in occlusion.
- Spacers when spaces have closed or the crowns of erupting teeth have penetrated alveolar bone.

The following restorative expenses are not covered:

- Replacement of crowns, fixed partial dentures, and removable prosthetic appliances (dentures, full and partial) within five years of restoration.
- Cast restorations when the tooth can be restored with an amalgam or with a composite resin restoration.
- Composite resin restorations on posterior teeth.
- Dowels, posts, and pins unless insufficient coronal structure remains to retain the crown restoration.
- Any porcelain cast metal crown or porcelain fused to metal crown for patients under age 16 (allowance will be made for acrylic or stainless steel crown).
- Two restorations on a single tooth surface during one visit.
- Permanent restorations performed within two months of remineralization (recalcification).
- Allowance for multiple restorations on one tooth that exceed the cost of a covered crown.
- Pulp capping unless the pulp is exposed or nearly exposed.
- Crowns with defective margins.
- Grossly under-filled or over-filled root canal fillings.
- Interim partial dentures (stayplates) except (1) to replace extracted anterior teeth for adults during healing period; (2) as an anterior space maintainer for children; or (3) as a temporary alternative to a permanent prosthesis in the presence of progressive periodontal disease likely to lead to further tooth loss.

In addition to the above exclusions that are specific to diagnostic/preventive or restorative services, dental benefits will not be paid for the following:

- Dental x-ray examinations made because of dental injury resulting from an Accident.
- Any treatment performed by someone other than a licensed Dentist, except for charges for dental prophylaxis (cleaning and scaling) performed by a licensed dental hygienist.
- Charges for anesthesia, other than general anesthesia administered by a licensed Dentist in connection with covered oral surgery services.
- Replacement of a lost or stolen appliance more often than once every 5 years.
- Extra-oral grafts or implants or the removal of implants, except under special circumstances when preauthorized by the Fund Administrator.
- Replacement of an existing denture that, in the opinion of the attending Dentist, is or can be made satisfactory.
- Any treatment for bruxism, including any removable dental appliances that are designed to minimize the effects of bruxism (grinding) and other occlusal factors.
- Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joint or associated musculature, nerves, and other tissues.
- Any services or procedures started before the patient became eligible for services under the Plan.

- Prescribed Drugs, premedication, or analgesia, unless dental necessity is documented.
- Experimental procedures.
- Any Hospital costs or any additional fees charged by the Dentist for Hospital treatment.
- Services with respect to congenital (hereditary) or developmental (following birth) malformations or Cosmetic surgery or Dentistry for purely Cosmetic reasons, including, but not limited to: cleft palate, maxillary and mandibular (upper and lower jaw) malformations, enamel hypoplasia (lack of development), fluorosis (a type of discoloration of the teeth), and anodontia (congenitally missing teeth).
- Services for injuries or conditions that are payable under Workers' Compensation or employer liability laws.
- Services that are provided by any federal or state government agency or are provided without cost by any municipality, county, or other political subdivision (except Medi-Cal benefits).
- Dental supplies or services for which benefits are provided under any other group plan or any other Hospital, surgical, or medical benefit or service plan, union welfare plan, or employee benefit plan for which any Employer, directly or indirectly, makes Contributions or payroll deductions.
- Cosmetic procedures (other than covered orthodontic treatment).

SHORT TERM DISABILITY BENEFITS

Who is Eligible for Benefits?

The benefits described in this chapter are available **only** to Active Employees (not Dependents) who become Totally Disabled (as defined by the Plan) while you are eligible for the coverage. Please refer to the Definitions chapter of this document for the Fund's definition of "Totally Disabled." Short term disability benefits are self-insured by the Plan.

Summary of Employee Short Term Disability (STD) Benefits	
Weekly Benefit	• $40 for the first 26 weeks of disability after the waiting period • $120 for the 27th week through 52nd week, if disability continues
Daily Benefit	1/7th of the weekly benefit
Disability Waiting Periods	7 days for both injury and Illness
Maximum Payment Period	52 weeks

How the Plan Works

A benefit will be paid to you if you become Totally Disabled while you are eligible for STD coverage. Benefit payments start after you satisfy the waiting period and may continue for up to 52 weeks. No benefits will be paid after 52 weeks, even though you may still be disabled. For partial weeks, the daily benefit is 1/7th of the weekly benefit shown in the above chart.

In order to receive benefits, you must be:

- Totally Disabled: and
- Under the care of a Physician or other Health Care Practitioner as defined in the Definitions chapter.

The disability waiting period and the maximum payment period outlined in the summary above apply separately to each covered period of Total Disability.

More Than One Disability

Any two periods of Total Disability will be considered one Period of Disability unless:

- You have returned to work on a full-time basis for at least two full consecutive weeks between the two periods of disability, or
- The later disability is due to an injury or Illness entirely unrelated to the causes of the earlier disability and begins after you have returned to work on a full-time basis.

Exclusions from Coverage

No disability benefit will be paid for:

- A disability for which benefits are excluded by the "General Limitations and Exclusions" section of this SPD,
- Any period during which you are not under the care of a Physician who certifies that you are Totally Disabled, or
- Employment-related disabilities.

Appeal Rights

See the Chapter title "Claims Filing and Appeals Procedures" beginning on page 60 for information regarding appealing a short term disability coverage claim denial.

LIFE, AD&D AND SURVIVOR INCOME BENEFITS

How the Plan Works

The Life, Accidental, Death and Dismemberment ("AD&D") and Survivor Income insurance benefits (described here as "insurance benefits") help protect you and your family against the financial consequences of death or serious injury. These benefits are provided through an insurance policy issued by the Reliastar Life Insurance Company ("the Insurance Company"), whose phone number and website is listed on the Quick Reference Chart at the beginning of this SPD. The following description is a summary of the Life, AD&D and Survivor Income insurance benefits available. Please call the Fund Administrator for a copy of the booklet that explains the full terms and conditions of these benefits. If there is a discrepancy between this summary and documents issued by the insurance company, the insurance company's document will control.

If you have questions about your insurance benefits, including your right to convert to an individual policy should you lose eligibility in the group policies, you can call the Fund Administrator at the number listed on the Quick Reference Chart at the beginning of this booklet.

If you are eligible for coverage as an Active Employee, below is a summary of the available benefits. Please note:

- Your life insurance benefit pays a lump-sum benefit to your Beneficiary if you die.
- The AD&D benefit pays a lump-sum benefit to you in the event of your accidental dismemberment, or to your Beneficiary in the event of your accidental death. AD&D is not available for Dependents.
- The survivor income benefit provides a monthly income for your surviving Dependents if you die.
- Dependent life insurance benefits provide coverage for your Spouse and eligible Dependent Children. If one of them dies while eligible for coverage, a lump sum benefit is paid to you.

SUMMARY OF LIFE, AD&D AND SURVIVOR INCOME INSURANCE BENEFITS	
Life insurance (Employee)	$10,000
Accidental Death and Dismemberment (Employee)	$10,000 (maximum benefit)
Life Insurance (Spouse or Domestic Partner)	$1,500
Life Insurance (child) • **Under 14 days;** • **14 days but under 6 months of age;** • **6 months but under 26 years of age.**	 Not covered $100 $1,500
Survivor Income Life Insurance	$341.48 per month; maximum of 60 months

Your Beneficiary

When you enroll in the Fund, you will be asked to fill out a death benefit Beneficiary designation form. You may name any person or persons you wish and you may name the portion of the benefit that is to go to each such Beneficiary. If you name more than one Beneficiary, but don't

assign the portion that is to go to each Beneficiary, the benefit will be divided equally among them. Your Beneficiary designation will apply to your insurance benefits.

If you do not designate a Beneficiary or if your Beneficiary dies before you, the benefit will be paid (in this order) to the surviving individual(s) in the first of the following groups that has at least one surviving member:

- your Spouse or Domestic Partner,
- your children,
- your parents,
- your siblings,
- your estate.

Changing Your Beneficiary

You may change your Beneficiary designation at any time by completing a new Beneficiary designation form and sending it to the Fund Administrator. The change or changes will not be effective until the Fund Administrator receives the new form. You do not need anyone's consent to change your Beneficiary designation. However, designation or revocation of a Beneficiary by any means other than a signed Beneficiary form provided by and filed with the Fund Administrator will not be effective.

Life Insurance

If you die while you are eligible for benefits, your designated Beneficiary or beneficiaries will receive a lump-sum benefit. To receive benefits your Beneficiary must be living on the tenth day after your death.

Disability Extension

If you become Totally Disabled while covered by this benefit before you reach age 60, life insurance protection is extended up to age 65, as long as you remain disabled, and provided you meet the conditions explained below. The amount of your life insurance benefit under the disability extension is determined by the schedule in effect at the time you became disabled. You are eligible to apply for the disability extension if:

- You became Totally Disabled before your 60th birthday;
- You were eligible for the Life Insurance benefit on the date you suffered the Illness or injury causing your Total Disability; and
- **You provide written notice to the insurance company of your Total Disability within 12 months of becoming Totally Disabled** (or as soon as reasonably possible). Such notice must be submitted while you are still living and still Totally Disabled.

The Disability Extension lasts as long as you remain Totally Disabled up to age 65. The insurance company will require you to submit proof of your Total Disability and may require you to undergo a medical examination (at no cost to you). You may be required to have ongoing medical examinations, but not more often than once per year.

Disability Extension will end the earliest of:

- the date you are no longer Totally Disabled;
- the date on which you fail to supply proof of your Total Disability to the insurance company listed on the Quick Reference Chart; or
- the date you turn 65 years of age.

If your disability extension expires but you have returned to covered work and eligibility for benefits under the Plan, your life insurance will resume under the Fund's group policy currently

in effect (if any). If your extension expires and you are no longer meet the Plan eligibility requirements, you may be entitled to convert your policy into an individual life insurance policy (see below).

Application for your Disability Extension, and notice and proof of your disability can be sent to the Fund Administrator.

Dependent Life Insurance

If you are covered as an Active Employee, the Plan also provides a limited life insurance benefit in the event of the death of:

- your Spouse or Domestic Partner,
- your eligible Dependent Child from the age of 14 days until his/her 26^{h} birthday;

The amount of this benefit is shown in the Summary of Benefits above and is payable, provided your Spouse, Domestic Partner, or eligible child is not also covered under the Plan as an Active Employee, is not on active military duty and lives inside the United States.

Your Dependents' life insurance coverage ends on the earliest of:

- the date your coverage ends
- the date you retire
- the date the person no longer qualifies as an eligible Dependent
- the date your disability extension starts

Accidental Death & Dismemberment Insurance (AD&D)

The AD&D insurance benefit covers Active Employees only and is paid if you die or are severely injured in a covered Accident.

Your maximum benefit amount is shown on in the Summary of Benefits above. The following schedule shows what portion of the maximum benefit is paid for losses that result due to and within 180 days of a covered Accident.

SCHEDULE OF AD&D BENEFITS	
DESCRIPTION OF LOSS	**BENEFIT**
Life, Both hands, both feet or sight of both eyes, One hand and one foot, Speech and hearing in both ears, One hand or foot and sight of one eye	Full maximum benefit
One hand or one foot, sight of one eye	One-half the maximum benefit
Speech, hearing in both ears, thumb and index finger of same hand	One-fourth of maximum benefit

Loss of a hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint. Loss of an eye means the entire and permanent loss of the sight of that eye. Loss of speech and hearing means total and permanent loss of speech and hearing. Loss of thumb and index finger mean loss by being permanently, physically, entirely severed. Note that the death benefit that is paid under AD&D insurance is in addition to the life insurance benefit described in the previous section.

Exclusions

AD&D benefits will not be paid for any of the following resulting in injury or death:

- Suicide or intentionally self-inflicted injury, while sane or insane.

- Caused by physical or mental Illness.
- Bacterial infection or bacterial poisoning. Exception: Infection from an acute 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 doctor – which is illegal – not taken as directed by a doctor or the manufacturer.
- Injury resulting from 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.

Survivor Income Insurance

In the event you die while covered by this benefit, a monthly income will be paid to your Beneficiary for a total of 60 months, starting on the first day of the month following the date you died. The survivor income insurance benefit payable to your Beneficiary is shown in the Schedule of Benefits at the beginning of this chapter.

If you designate your Spouse as primary Beneficiary and your children as contingent beneficiaries, and your Spouse dies before receiving 60 monthly benefit payments, the balance of the monthly payments will be paid to the surviving children who were designated as contingent beneficiaries. If there are no surviving children when your Dependent Spouse dies, the unpaid balance of the commuted value of the monthly benefit will be paid to your deceased Spouse's estate.

If you designate your child or children as your beneficiaries, and a child who is receiving payments dies before 60 payments have been made, the balance of the monthly benefit will be divided equally among any other children who were designated as beneficiaries. If there are no surviving children, the balance remaining will be paid in a lump sum to the estate of the last child to die.

If the last designated Beneficiary dies before a total of 60 payments have been made, the commuted value of the remaining monthly payments will be paid in a lump sum to the estate of that Beneficiary.

Filing Claims for Life, AD&D or Survivor Income Insurance

If you die, your family or Beneficiary should notify the Fund Administrator immediately. To claim a dismemberment benefit, you or your representative should notify the Fund Administrator. The Fund Administrator will advise what forms and certificates need to be filed to apply for the life insurance benefit. The Fund Administrator will forward your claim to the insurance company for processing. The insurance company will either make a payment or issue a denial of your claim within 90 days of receiving it. In some cases, the insurance company may require more than 90 days to make a decision. In such a case, it will extend its time to reach a decision by another 90 days, and will inform you of the reason for the extension.

Appealing a Denial of Your Life, AD&D or Survivor Income Claim

If the insurance company denies your claim, it will provide you with a notice of the denial which will contain the reason for the denial and refer to the provisions in the plan or policy on which the denial is based. You may appeal the denial, but your appeal must be submitted directly to the insurance company listed in the Quick Reference Chart at the beginning of this SPD.

In some cases, the insurance company may need additional information in order to decide your claim, in which case the denial letter will indicate the information you must provide. The notice will also inform you of your right to appeal the claim, and the manner and time in which you must do so.

If you decide to appeal, you or your authorized representative must submit a written letter of appeal to the insurance company within 60 days from the date you receive the notice denying your claim (unless you have good reason for delay). You are entitled to review relevant documents related to your claim, and also to submit written comments, documents, records and other information relating to your claim.

The insurance company will review your claim and issue a decision within 60 days of receiving your appeal and make all final decisions with respect to your claim for Life, AD&D and Survivor Income insurance benefits. The written decision will be written in an understandable way, state the reason(s) for the decision, and reference the provisions on which the denial is based.

If the insurance company requires more time to decide your appeal, it will extend its time to respond for another 60 days, and will inform you of the reason for the extension. If you do not receive a decision within these time limits, the claim can be considered denied. For information regarding your additional rights of appeal under federal law, see your "Statement of ERISA Rights."

The insurance company has final discretionary authority to determine all questions of eligibility and status to interpret and construe the terms of the Life, Survivor Income and AD&D Insurance policies.

When Life, AD&D or Survivor Income Coverage Ends

Your coverage under these policies ends on the earliest of the following:

- The date your eligibility for Fund benefits ends,
- When premium payments or Contributions to the Fund on your behalf end,
- When your Employer (or former Employer) stops being a Contributing Employer,
- With regard to AD&D or Survivor Income life insurance, the date you retire,
- The date you enter active duty in any armed forces, or
- The date on which the Fund cancels the ReliaStar group policy applicable to your Plan.

Continuation of Coverage for Active Employees

Coverage may continue during certain periods of qualifying absence (described below) when it would otherwise end because you failed to meet the eligibility requirements (although not past age 65).

Family or Medical Leave of Absence

If you take an approved leave of absence under the federal Family and Medical Leave Act of 1993 (FMLA) or the California Family Rights Act (CFRA), coverage for you and your eligible Dependents will continue during the approved leave, as required for the length of time and in the manner allowed under the applicable federal or state law.

During a Labor Dispute

If you stop work due to a labor dispute and your Plan eligibility is discontinued, you may continue coverage for you and your eligible Dependents during the labor dispute if you make a payment each month for coverage under the rules described below, and payments are collected from at least 75% of the Employees who stop work because of the labor dispute and made to the insurance company in a timely manner. Here are the rules you must follow:

- You must make your monthly payments on each premium due date to the Fund.

- The amount of your monthly payment will be 120% of the amount you and your Employer would have to pay to the trust on your behalf if you did not stop work.
- The continuation will end on the earlier of: (a) the date you start active full-time work with an Employer other than the Employer you stopped working for due to the labor dispute; or (b) the last day of the sixth month that follows the date you stop working.

Conversion Privilege for Group Life & Survivor Income Insurance Coverage

When your Fund coverage ends, you, and in certain cases your covered Dependents, may be entitled to convert your group life insurance and group survivor income insurance coverage to an individual policy with the Insurance Company. You usually must elect this coverage within 31 days after coverage ends. You can get more information on conversion rights from the Fund Administrator.

CLAIMS FILING AND APPEALS PROCEDURES

For benefits under the self-funded Indemnity Medical Plan (including Prescription Drugs claims), Substance Abuse/Chemical Dependency program, Short Term Disability, the Dental and Vision Plans you or the Provider must file a claim. The claim procedures are described here. If your claim has been denied in whole or in part, you have the right to appeal the decision. The appeals procedures are also described here.

For claims administration and appeals under the insured Kaiser HMO and the insured Life Insurance, AD&D and Survivor income plan refer, respectively, to Kaiser's *Evidence of Coverage* and the Insurance Company's *Certificate of Coverage* for details. You can obtain a copy of the Evidence of Coverage from Kaiser or the Fund Administration. You can obtain a Certificate of Coverage from the Fund Administrator.

TIME LIMIT FOR INITIAL FILING OF CLAIMS

All claims must be submitted to the Plan within 12 months from the date of service. No Plan benefits will be paid for any claim submitted after this period.

Exception: Where an Anthem Blue Cross provider's PPO Network agreement allows for a longer time period than twelve months, the claim filing limits contained in that agreement will apply as the Plan terms. However, charges by or claims for out-of-network providers will always be deemed untimely if they are not received by the Administrative Office within twelve months from the date of service.

Additional Information Needed

There may be times during the filing or appeal of a claim that you are asked to submit additional information. You will be told how much time you to submit this additional information.

Review of Issues That Are Not a Claim as Defined by the Plan

A Plan Participant may request review of an issue (that is not a claim as defined by the Plan, for example, the Plan's determination that you or your Dependent is ineligible for coverage) by writing to the Board of Trustees (see the information listed on the Quick Reference Chart on page 3 of this booklet. The request will be reviewed and the Participant will be advised of the decision within the timeframes applicable to post-service claims.

Authorized Representative

You can act on your own behalf in filing and/or appealing your claim, or you may ask another person to act as your Authorized Representative. If you designate an Authorized Representative, he or she will receive all communications about your claim or appeal.

Types of Claims

To file claims for any of the Plan's health care benefits, follow the procedures as described in this section. The claims procedure you follow will depend on whether your claim for benefits is a claim involving urgent care, a pre-service claim, or a post-service claim.

A pre-service claim is any claim for services not yet performed but is not for urgent care. An urgent care claim is a claim for medical care or treatment if delays could seriously jeopardize your life or health or your ability to regain maximum function, or would, in the opinion of your Physician, subject you to severe pain that can only be effectively managed through the requested course of treatment. Any claim for health care benefits under the Plan that is not an urgent care claim, a pre-service claim, or a concurrent care claim (see below) is considered a post-service claim.

Pre-Service Claims

The Fund Administrator will issue a decision within 15 days after receipt of the written or electronic claim. If an extension is necessary, then a decision will be issued within 30 days. You will receive written notice of the extension before the end of the initial 15-day period, which will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit the necessary information, the notice will describe the required information, and you will have 45 days to provide the requested information. The time period in which a decision will be issued is delayed from the date the extension was sent out until you respond. If you do not provide the requested information within the 45-day period, your claim will be denied.

Urgent Care Claims

The Fund Administrator will issue a decision as soon as possible and within 72 hours after receipt of the written or electronic claim. If more information is required to determine the claim, you will be notified as soon as possible but within 24 hours, and given at least 48 hours to provide the requested information. If you do not provide the requested information within the 48-hour period, your claim will be denied.

Post-Service Claims

The Fund Administrator will issue a decision within 30 days after receipt of the written or electronic claim, unless an extension is necessary, in which case a decision will be issued within 45 days. Written notice of the extension will be provided to you before the end of the initial 30-day period and will state the reason(s) for the extension and the date you can expect a decision. If an extension is necessary because you failed to submit the necessary information, the notice will describe the required information, and you will have 45 days to provide the requested information. The time period in which a decision will be issued is delayed from the date the extension was sent out until you respond. If you do not provide the requested information within the 45-day period, your claim will be denied.

Concurrent Care Claims

In the case of a concurrent care claim, where health care treatment is reduced or terminated before the end of the approved period of time or number of treatments, the Fund Administrator will notify you sufficiently in advance of the reduction or termination to allow you to appeal the decision if you choose to do so and have the appeal decided before the benefit is reduced or terminated.

If an ongoing course of treatment was previously approved for a specific period of time or number of treatments, and you request to extend treatment in a non-urgent circumstance, your request will be considered a new claim and decided according to post-service or pre-service time frames, whichever applies. If the request involves urgent care, any claim to extend a course of treatment will be decided as soon as possible but within 24 hours, provided the claim is submitted at least 24 hours prior to the prescribed end of the course of treatments.

Disability Claims

A disability claim is a claim for which to receive the benefit the Plan must first determine whether you are disabled. The Fund Administrator determines if you are eligible for disability benefits.

How to File a Post-Service Claim for Benefits Under This Plan

A claim that is filed after you receive a service is a “Post-Service claim” Plan benefits for post-service claims are considered for payment upon receipt of a written (or electronic where appropriate) proof of claim (or a bill).

How to File a Claim for Medical Benefits

If you receive covered services from a PPO provider, your claim will be filed for you by the Provider.

A non-PPO provider will often submit claims for you as well. However, if the non-PPO provider does not submit your claims, you will need to file a claim yourself. Electronic claims should be submitted to Anthem using payer ID 47198. Paper claims can be mailed to:

Anthem Blue Cross
PO Box 60007
Los Angeles, CA 90060-0007

If the provider is Non-PPO and requires the patient to pay at the time of the service, the claim should be submitted directly to the Fund Office. In addition, foreign claims must also be sent to the Fund office at the following address:

Bay Area Delivery Drivers Security Fund
4160 Dublin Blvd Ste 400
Dublin, CA 94568

How to File a Claim for Dental Benefits

You or your Dentist's office may submit a claim form to Premier Access for services rendered. The dental office will usually submit an ADA claim form or submit the claim electronically. Paper claims should be sent to Premier Access at the following address:

Premier Access Insurance Company
P.O. Box 659010
Sacramento, CA 95865-9010

How to File a Claim for Alcoholism and Chemical Dependency Benefits

Inpatient Detoxification and Rehabilitative Treatment Claims

Like the Anthem Blue Cross PPO versus the Non-Network providers under the Self-Insured Medical Plan, you have a choice between going to a TAP facility (for which you will have no or little out-of-pocket costs) and going to a non-TAP facility (for which you will have out-of-pocket costs). If you do not consult TAP first and are admitted to a Hospital or treatment facility, show your Blue Cross identification card to the admitting office and tell the admitting office that the claim must be submitted directly to Blue Cross electronically.

Teamsters Assistance Program of Northern California
80 Swan Way, Suite 320
Oakland, California 94621

Any questions regarding substance abuse or chemical dependency treatment should be directed to TAP at 510-562-3600.

Outpatient Treatment Claims

We encourage you to contact TAP prior to receiving outpatient treatment. You will be referred to a provider by TAP and do not need to submit a claim because the provider will send the bill directly to TAP.

How to File a Claim for Outpatient Prescription Drug Benefits

THE PLAN DOES NOT COVER OUTPATIENT PRESCRIPTION DRUGS FILLED AT A PHARMACY THAT IS NOT PART OF THE OPTUMRX NETWORK.

How to File a Claim for Vision Benefits

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

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

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

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

Appropriate Claims Administrator

The companies/organizations outlined below are the "Appropriate Claims Administrator" for the types of claims outlined below and in this chapter.

Types of Claims Processed	Appropriate Claims Administrator
Medical and Dental claims.	HS&BA (the "Fund Administrator")
Preauthorization for inpatient admissions and certain medical services	Anthem Blue Cross of California
Substance Abuse	HS&BA in conjunction with the Teamsters Assistance Program of Northern California (TAP)
Prescription Drugs	OptumRx
Vision Plan	VSP
Short Term Disability (STD)	HS&BA
Life Insurance/Accidental Death and Dismemberment Claims	ReliaStar Life Insurance Company

How to File a Post-Service Claim for Benefits

The Appropriate Claims Administrator will review your post-service claim no later than 30 calendar days from the date the claim is received. You will be notified if you did not properly follow the post-service claims process.

(a) This 30-day period may be extended one time for up to 15 additional calendar days if the Appropriate Claims Administrator determines that an extension is necessary due to matters beyond its control, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 30-day period using a written Notice of Extension.

(b) The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues. You will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.

(c) If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the date on which you respond.

(d) The Appropriate Claims Administrator will then make a claim determination no later than 15 calendar days from the earlier of the date the Plan receives the additional information or the date displayed in the Notice of Extension on which the Plan will make a decision if no additional information is received.

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

If the post-service claim is approved, you will be notified in writing (or electronically, as applicable) on a form commonly referred to as an Explanation of Benefits (EOB). The provider of service (or you when applicable) will be paid according to Plan benefits.

If the post-service claim is denied in whole or in part, a notice of this initial denial will be provided to you in writing (or electronically, as applicable) in addition to the EOB form. **If you disagree with a denial of a post-service claim**, you or your authorized representative may ask for a post-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period. **If you disagree with the decision on appeal you have one year from the date of the appeal denial to file suit in federal court. A lawsuit filed after this one-year period will be time-barred.**

Appeal of a Denial of a Post-Service Claim

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

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

(a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

(b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

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

(e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

(f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, Drug or other item is Experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:

1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and

2) provide the identification of medical or vocational experts whose advice was obtained in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.

2. The Plan will make an appeal determination according to the following timeframes:

(a) **If an appeal is filed with the Plan more than 30 days before the next Board meeting**, the review will occur at the next Board meeting date.

(b) **If an appeal is filed with the Plan within 30 days of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

(c) If special circumstances require a further extension of time, the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(d) After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than five calendar days after the benefit determination is made.

3. You have the right to review documents relevant to the claim and to submit your own comments in writing. These materials will be considered during the Plan's review of the denial. Your claim will be reviewed by a person other than the person that originally denied the claim and who is not subordinate to the person who originally denied the claim.

4. If the claim was denied due to medical necessity, Experimental treatment, or similar exclusion or limit, the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

You will receive a notice of the appeal determination.

How to File an Urgent Care Claim for Benefits

1. If your claim involves urgent care (as determined by your attending Health Care Professional), You may file an urgent care claim or the Plan will recognize a Health Care Professional as your authorized representative.

2. You (or your Health Care Professional) can make an Urgent care claim by calling or writing the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart on page 3 of this document.

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

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

rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

5. You will be notified of the Plan's benefit determination as soon as possible but **no later than 72 hours** after receipt of an urgent care claim by the Appropriate Claims Administrator. You will be notified if you fail to follow the urgent care claim procedures or fail to provide sufficient information to determine whether or to what extent benefits are covered or payable under the Plan.
6. **If you fail to provide sufficient information to decide an urgent care claim**, you will be notified as soon as possible, but no later than 24 hours after receipt of the urgent care claim by the Appropriate Claims Administrator, of the specific information necessary to complete the urgent care claim and you will be allowed not less than 48 hours to provide the information. You will then be notified of the Plan's benefit determination on the urgent care claim as soon as possible but no later than 48 hours after the earlier of the receipt of the needed information **or** the end of the period of time allowed to you in which to provide the information.
7. **If the urgent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
8. **If the urgent care claim is denied** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice provided no later than 3 calendar days after the oral notice.
9. **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. If you disagree with the decision on appeal you have **one year** from the date of the appeal denial to file suit in federal court. A lawsuit filed after this one-year period will be time-barred.

Appeal of a Denial of an Urgent Care Claim

1. You may request an appeal review of an urgent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator whose contact information is listed on the Quick Reference Chart in this document.
2. The Plan will make a determination on the appeal (without the opportunity for an extension) as soon as possible but no later than **72 hours** after receipt of the appeal.

How to File a Concurrent Claim for Benefits

1. If a decision is made to reduce or terminate an approved course of treatment, you will be provided notification of the termination or reduction sufficiently in advance of the reduction or termination to allow you to appeal and obtain a determination of that Adverse Benefit Determination before the benefit is reduced or terminated.
2. The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

3. Concurrent claims that are an urgent care claim will be processed according to the initial review and appeals procedures and timeframes described in the Urgent care claim section of this chapter.
4. Concurrent claims that are not an urgent care claim will be processed according to the initial review and appeals procedures and timeframes applicable to the claims as noted under the Pre-service or Post-service claim sections of this chapter.
5. **If the concurrent care claim is approved** you will be notified orally followed by written (or electronic, as applicable) notice provided no later than 3 calendar days after the oral notice.
6. **If the concurrent care claim is denied,** in whole or in part, you will be notified orally with written (or electronic, as appropriate) notice. **If you disagree with a denial of a concurrent claim,** you or your authorized representative may ask for an appeal review as described below. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period.

Appeal of a Denial of a Concurrent Care Claim

1. This Plan maintains a one level appeals process. You may request an appeal review of a concurrent care claim by submitting the request orally (for an expedited review) or in writing to the Appropriate Claims Administrator, whose contact information is listed on the Quick Reference Chart in this document.
2. You will be provided with:
   (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   (d) any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim, free of charge. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;
   (e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
   (f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, Drug or other item is Experimental, investigational, not Medically Necessary or not appropriate, the appropriate named fiduciary will:
      - ✓ consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
      - ✓ provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination

without regard to whether the advice was relied upon in making the benefit determination.

3. A determination will be made on the appeal (without the opportunity for extension) as soon as possible before the benefit is reduced or treatment is terminated.

   The notice of appeal review for the concurrent claim may be provided orally (for urgent care claims), with written (or electronic, as appropriate) notice. You will receive a notice of the appeal determination.

How to File a Pre-service Claim for Benefits

1. A claim for pre-service is a claim submitted before the service is rendered that is not an urgent care claim (as described above). It must be made by a claimant or the claimant's authorized representative in accordance with this Plan's claims procedures.
2. A pre-service claim must be submitted (orally or in writing) in a timely fashion (as discussed in the Required Preauthorizations chapter of this document) to the Appropriate Claims Administrator.
3. The pre-service claim will be reviewed no later than 15 calendar days from the date the pre-service claim is received by the Appropriate Claims Administrator. If you do not follow the pre-service claim filing process, you will be notified as soon as possible or within 5 calendar days from your request.
4. The 15 calendar day review period may be extended one time for up to 15 additional calendar days if it is determined that an extension is necessary due to matters beyond the control of the Appropriate Claims Administrator, the date by which it expects to make a decision and notifies you prior to the expiration of the initial 15-day period by using a written Notice of Extension.
5. If a period of time is extended due to failure to submit information, the time period is tolled from the date on which the Notice of Extension is sent until the date on which you respond.
6. The Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision (such as your failure to submit information necessary to decide the claim) and additional information needed to resolve those issues.
7. In either case noted above, you will be notified of the need for additional information in the Notice of Extension and allowed at least 45 calendar days from receipt of the Notice of Extension to provide the additional information.
8. A claim determination will be made no later than 15 calendar days from the earlier of the date the additional information is received or the date displayed in the Notice of Extension on which a decision will be made if no additional information is received.
9. The Plan will provide you free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.
10. **If the pre-service claim is approved** you will be notified orally and in writing (or electronic, as applicable).
11. **If the pre-service claim is denied in whole or in part**, a notice of this initial denial will be provided to you orally and in writing (or electronic, as applicable).

12. **If you disagree with a denial of a pre-service claim,** you or your authorized representative may ask for a pre-service appeal review. You have 180 calendar days following receipt of an initial denial to request an appeal review. The Plan will not accept appeals filed after this 180-calendar day period. If you disagree with the decision on appeal you have **one year** from the date of the appeal denial to file suit in federal court. A lawsuit filed after this one-year period will be time-barred

Appeal of a Denial of a Pre-service Claim

1. This Plan maintains a one level appeals process. Appeals must be submitted in writing to the Fund Administrator whose contact information is listed on the Quick Reference Chart in this document. You will be provided with:
   (a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;
   (b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;
   (c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;
   (d) any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied claim, free of charge. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date. Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date;
   (e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;
   (f) in deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, Drug or other item is Experimental, investigational, not Medically Necessary or not appropriate, the Fund Administrator will:
      1) consult with a Health Care Professional who has appropriate experience in the field of medicine involved in the medical judgment and is neither an individual who was consulted in connection with the Adverse Benefit Determination that is the subject of the appeal nor the subordinate of any such individual; and
      2) provide the identification of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with an Adverse Benefit Determination without regard to whether the advice was relied upon in making the benefit determination.
2. There is **no extension permitted** to the Plan in the appeal review process. You will be sent a written (or electronic, as appropriate) notice of the appeal determination as discussed below.
3. If the claim was denied due to medical necessity, Experimental treatment, or similar exclusion or limit the Plan will consult with a Health Care Professional who has appropriate training and experience in the field of medicine involved in the medical judgment and who was not consulted in the original denial, nor the subordinate of any such individual.

You will receive a notice of the appeal determination.

How to File a Claim for Disability Income Benefits (Disability Claim Process)

A claim for disability benefits is a request for disability plan benefits including,

- A claim for short term disability benefits (see benefits beginning on page 53);
- A claim for coverage for your disabled child over the age of 26 (see page 5) ; and
- A claim for an extension of medical coverage for up to one year for your or your Dependent if either you or your Dependent is totally disabled at the time your coverage ends (with the extended coverage being limited to services required for the treatment of illness or injury causing the disability (see page 13).

In the case of disability benefit claim determinations and claim appeals, the persons involved with adjudicating disability claims and disability appeals (such as claim adjudicators and medical or vocational experts) will act independently and impartially.

For disability benefits you must get a disability claim form from the Fund Administrator, complete the patient portion of the form, then give the form to your physician to complete the health care provider section of the form. Return the completed disability claim form to the Fund Administrator whose contact information is listed on the Quick Reference Chart in this document.

All disability claims must be submitted to the Plan within 90 days from the date of onset of the disability. No Plan benefits will be paid for any claim submitted after this period.

The Fund Administrator ill determine your claim no later than 45 calendar days after receipt of the claim for disability benefits by the Fund Administrator. You will be notified if you did not follow the disability claim process or if you need to submit additional medical information or records to prove a disability claim and provided 45 calendar days in which to obtain this additional information. This 45-day period may be extended for up to 30 calendar days provided the Fund Administrator determines that an extension is necessary due to matters beyond their control and notifies you in writing (or electronically, as applicable) prior to the expiration of the initial 45-day period, that additional time is needed to process the claim, the special circumstances for this extension and the date by which it expects to render its determination.

If, prior to the end of this first 30-day extension, the Fund Administrator determines that due to matters beyond its control a decision cannot be rendered within the first 30-day extension period, the determination period may be extended for up to an additional 30 calendar days provided you are notified prior to the first 30-day extension period of the circumstances requiring the second extension and the date a decision is expected to be rendered.

A Notice of Extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision and the additional information needed to resolve those issues. If the Fund Administrator needs additional information from you to make its decision, you will have at least 45 calendar days to submit the additional information.

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

If the claim for disability benefits is approved, you will be notified in writing (or electronically, as applicable) and benefit payments will begin.

If the claim for disability benefits is denied in whole or in part, a notice of this initial denial (an Adverse Benefit Determination) will be provided to you in writing. This notice of initial denial will:

(a) give the specific reason(s) for the denial of disability benefits (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the plan in connection with a claimant's adverse benefit determination, and (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the plan (if applicable);

(b) reference the specific Plan provision(s) on which the determination is based;

(c) contain a statement that you are entitled to receive upon request, free access to and copies of documents, records and other information relevant to your claim;

(d) describe any additional information needed to perfect the claim and an explanation of why such added information is necessary;

(e) provide an explanation of the Plan's appeal procedure along with time limits;

(f) contain a statement that you have the right to bring civil action under ERISA Section 502(a) following an appeal;

(g) describe any applicable contractual limitation periods on benefit disputes (such as the Plan's one-year time limit on when a lawsuit may be filed following an appeal denial);

(h) if the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request; and

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

(j) Include a statement that if a Participant is not proficient in English and has questions about a claim denial, they should contact the Fund Administrator to find out if assistance is available.

Appeal of a Denial of a Disability Claim

If you disagree with a denial of a disability 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. Appeals must be submitted in writing to the Board of Trustees, whose contact information is listed on the Quick Reference Chart in this document. You will be provided with:

(a) upon request and without charge, reasonable access to and copies of all relevant documents, records and other information relevant to your claim for benefits;

(b) the opportunity to submit written comments, documents, records and other information relating to the claim for benefits;

(c) a full and fair review that takes into account all comments, documents, records and other information submitted by you, without regard to whether such information was submitted or considered in the initial benefit determination;

(d) automatically and free of charge, with any new or additional evidence considered, relied upon, or generated by the Plan (or at the direction of the Plan) in connection with the denied disability claim. Such evidence will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you a reasonable opportunity to respond prior to that date.

Additionally, before the Plan issues an Adverse Benefit Determination on review based on a new or additional rationale, you will be provided, automatically and free of charge, with the rationale. The rationale will be provided as soon as possible (and sufficiently in advance of the date on which the notice of Adverse Benefit Determination on review is required to be provided) to give you reasonable time to respond prior to that date.

If the Plan receives new or additional evidence or rationale so late in the claim filing or claim appeal process that a claimant would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as the claimant has had such an opportunity.

(e) a review that does not afford deference to the initial Adverse Benefit Determination and that is conducted by an appropriate named fiduciary of the Plan who is neither the individual who made the Adverse Benefit Determination that is the subject of the appeal, nor the subordinate of such individual;

In deciding an appeal of any Adverse Benefit Determination that is based in whole or in part on a medical judgment, including whether a particular treatment, drug or other item is experimental, investigational, not Medically Necessary or not appropriate, the Board of Trustees will:

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

The Plan will make an appeal determination according to the following timeframes:

(e) **If an appeal is filed with the Plan <u>more than 30 days</u> before the next Board meeting**, the review will occur at the next Board meeting date.

(f) **If an appeal is filed with the Plan <u>within 30 days</u> of the next Board meeting**, the Board review will occur no later than the second meeting following receipt of the appeal.

(g) If special circumstances (such as the need to hold a hearing) require a further extension of time the Board's review will occur at the third meeting following receipt of the appeal. If such an extension is necessary, the Plan will provide to you a Notice of Extension describing the special circumstances and date the benefit determination will be made.

(h) After the Board makes their decision on the appeal, you will be notified of the benefit determination on the appeal no later than five calendar days after the benefit determination is made.

The Plan may obtain a 45-day extension if you are notified of the need and reason for an extension before expiration of the initial 45-day period.

You will receive a notice of the appeal determination. If that determination is adverse, it will include:

(a) the specific reason(s) for the adverse appeal review decision of disability benefits (including a discussion of the decisions and the basis for disagreeing with or not following the (1) views presented by the claimant to the plan of health care professionals treating the claimant and vocational professional who evaluated the claimant, (2) views presented by the medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's adverse benefit determination, (3) the claimant's disability determination made by the Social Security Administration that was presented by the claimant to the Plan (if applicable);

(b) reference the specific Plan provision(s) on which the determination is based;

(c) a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your claim;

(d) a statement that you have the right to bring civil action under ERISA Section 502(a) following the appeal;

(e) a description of any applicable contractual limitation periods on benefit disputes (such as the Plan's one-year time limit on when a lawsuit may be filed following an appeal denial);

(f) if the denial was based on an internal rule, guideline, protocol, standard, or similar criterion, a statement will be provided that such rule, guideline, protocol, standard, or criteria that was relied upon will be provided free of charge to you, upon request; and

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

(h) A statement that if you are not proficient in English and have questions about disability benefits, filing a claim for disability benefits or about a claim denial, you should contact the Fund Administrator for assistance.

No Additional Internal Appeals Process

The appeals process described above contains the entire appeals process under this Plan. This Plan does not offer an additional voluntary appeal process.

External Review of Claims

1. This External Review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section, references to "you" or "your" include you, your covered Dependent(s), and you and your covered Dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

2. You may seek further external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim, is denied and it fits within the following parameters:

   (a) The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is Experimental or investigational, or a determination whether the Plan is complying with the non-quantitative treatment limitation provisions of Code section 9812 and § 54.9812, which generally require among other things, parity in the application of medical management techniques. The IRO will determine whether a denial involves a medical judgment; and/or

   (b) The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time.

3. **External review is not available for** any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. In addition, this **external review process does not pertain** to claims for life/death benefits, AD&D, disability or the dental or vision plan.

4. Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on appeal.

5. There are two types of External Claims outlined below: Standard (Non-Urgent) Claims and Expedited Urgent Claims.

6. **External Review of Standard (Non-Urgent) Claims**.

   (a) Your request for external review of a standard (not urgent) claim must be made, in writing, **within four months of the date that you receive notice** of an Initial Claim Appeal Benefit Determination (first level of appeal). For convenience, these

Determinations are referred to below as an "Adverse Determination," unless it is necessary to address them separately.

(b) **Preliminary Review of Standard Claims**.

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

i 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;

ii The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan; or to a denial that is based on a contractual or legal determination; or to a failure to pay premiums causing a retroactive cancellation of coverage;

iii You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when you are not required to do so); and

iv You have provided all of the information and forms required to process an external review.

2) Within one business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

i If your request is complete and eligible for external review; or

ii 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)).

iii If your request is incomplete, the notice will describe the information or materials needed to complete the request, and allow you to complete the request for external review within the four-month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

(d) **Review of Standard Claims by an Independent Review Organization (IRO)**.

1) If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. Once the claim is assigned to an IRO, the following procedure will apply:

i 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, you are to submit such information within ten business days).

ii Within five business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

iii If you submit additional information related to your claim to the IRO, the assigned IRO must, within one 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, the Plan will provide written notice of

its decision to you and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

iv 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, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

v 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.

a) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

b) 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) but you must do so within **one year** of receiving the IRO's decision.

vi The assigned IRO's decision notice will contain:

a) 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, health care provider, claim amount (if applicable), diagnosis code and its corresponding meaning, and treatment code and its corresponding meaning, and reason for the previous denial);

b) The date that the IRO received the request to conduct the external review and the date of the IRO decision;

c) References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;

d) A discussion of the principal reason(s) for the IRO's decision, including the rationale for its decision and any evidence-based standards that were relied on in making the decision;

e) A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law);

f) A statement that judicial review may be available to you; and

g) 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.

7. **External Review of Expedited Urgent Care Claims**.

(a) You may request an expedited external review if:

1) 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

2) 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.

(b) **Preliminary Review for an Expedited Claim**.

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

(c) **Review of Expedited Claim by an Independent Review Organization (IRO)**.

Following the preliminary review that a request is eligible for expedited external review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

The assigned IRO, to the extent the information or documents are available and the IRO considers them appropriate, must consider the information or documents described in the procedures for standard review. In reaching a decision, the assigned IRO must review the claim *de novo* (as if it is new) and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

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

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

or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

2) 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) within **one year** of your receipt of the IRO's determination.

Limitation on When and Where a Lawsuit May Be Filed

You or any other claimant may not start a lawsuit or other legal action to obtain Plan benefits, including proceedings before courts or administrative agencies, **until after all administrative procedures have been exhausted** (including this Plan's claim appeal review procedures described in this document) **for every issue deemed relevant by the claimant**, or until 90 days have elapsed since you filed a request for appeal review if you have not received a final decision or notice that an additional 60 days will be necessary to reach a final decision. The law also permits you to pursue your remedies under Section 502(a) of the Employee Retirement Income Security Act without exhausting these appeal procedures if the Plan has failed to follow them properly. In addition, you are not required to exhaust external review before seeking judicial remedy. If you receive an adverse benefit determination you have **one year** from the date you receive the determination to file suit in federal court.

If you disagree with the decision of the IRO you have **one year** from the date of the denial to file suit. A lawsuit filed after this one-year period will be time-barred**.**

Any suit must be filed in the U.S. District Court for the Northern District of California.

Discretionary Authority of Plan Administrator and Designees

In carrying out their respective responsibilities under the Plan, the Board of Trustees or its delegate, other Plan fiduciaries, and the insurers or administrators of each Program of the Plan, have full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. The Board of Trustees also has the discretion to make all factual determinations arising under the Plan and any claims for benefits thereunder.

Elimination of Conflict of Interest

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

Facility of Payment

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

COORDINATION OF BENEFITS (COB)

How Duplicate Coverage Occurs

All of the benefits provided by this Plan are subject to this Coordination of Benefits Provision. This Plan does not coordinate benefits with an individual plan. This means that when a Plan Participant or Dependent is covered by an individual (non-group) plan/policy (including a policy through the Health Insurance Marketplace), this Plan will not pay benefits toward claims that are covered by that individual plan/policy.

If you are **not** entitled to Medicare, the following rules determine if the Bay Area Delivery Drivers Security Fund or another group plan will be the primary payer of your benefits:

- A plan without a coordination of benefits provision or with a provision that bars or substantially restricts (as determined by the Board of Trustees) coordination with this Plan is primary. In the event of coordination with a plan that contains a substantially restrictive coordination of benefits provision, the Trustees in their sole discretion may determine to pay benefits only in amount that would have been paid had the other plan not contained the substantially restrictive coordination of benefits provision. A substantially restrictive coordination of benefits provision is a provision in a coordinating plan, the purpose of which is to avoid payment of benefits that would otherwise be paid by application of the coordination of benefits rules described below. The Trustees have sole discretionary authority to determine whether a coordination of benefits provision is substantially restrictive.
- The plan covering the patient directly, *e.g.* the plan that covers the patient as an Employee rather than a Dependent, is the primary payer.
- The plan that covers the patient as an Active Employee is primary to a plan that covers the patient as a laid-off or retired Employee.
- If a patient whose coverage is provided under a right of continuation coverage pursuant to federal law (such as COBRA) or state law is also covered under another plan, the plan covering the patient as an Employee or Dependent pays before the plan covering the patient through continuation coverage.
- In the case of a Spouse, Domestic Partner, or Dependent Child (whose parents are not separated or divorced or have terminated their Domestic Partnership) who is covered as a Dependent under more than one plan: the plan that covers the primary Participant (i.e. the person through whom the Spouse, Domestic Partner or Child has coverage,) whose birthday (month and day) occurs earlier in the Calendar Year will pay benefits first. When primary Participants have the same birthday (month and day), the plan that has covered the Dependent longer pays first. This rule does not apply if the other plan does not have this provision; in such case, the other plan shall determine the order of benefit payments.
- In the case of a Dependent Child when the parents are separated or divorced or have terminated their Domestic Partnership, the order of payment for Dependent Children is:
    - The plan of the natural or adoptive parent with custody is the primary payer, or if a Qualified Medical Child Support Order ("QMSCO") designates a parent to be financially responsible for health care expenses of the child, that parent's plan is the primary payer.
    - In the case of a natural or adoptive parent with custody who has remarried, the plan of the natural or adoptive parent with custody pays benefits before the plan of the stepparent.
    - The plan of the stepparent with custody pays benefits before the plan of a natural or adoptive parent without custody.

If these rules do not determine which plan is the primary payer, then the plan that has covered the patient for the longest time will be primary.

The Plan has the right to release to (and obtain from) any insurance company, claims administrator, organization, or person, benefit information necessary to apply this coordination of benefit provision.

How Much This Plan Pays When It Is Secondary

Secondary Liability of this Plan: When this Plan pays second, it will pay, 100% of "Allowable Expenses" less whatever payments were actually made by the Plan (or plans) that paid first. It will reduce its benefits so that the total benefits paid or provided by all coordinating plans during a claim determination period is not more than 100% of total Allowable Expenses and in no case will this Plan pay more in benefits than it would have paid had it been the Plan that paid first.

Allowable Expense

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

- The difference between the cost of a semi-private room in a Hospital or Health Care Facility and a private room, unless the patient's stay in a private Hospital room is determined (by the Fund Administrator or designee) to be Medically Necessary.
- If the coordinating plans both determine benefits on the basis of an Allowed charge amount, any amount in excess of the highest Allowed Charge is not an allowable expense.
- If the coordinating plans both provide benefits or services on the basis of negotiated fees, any amount in excess of the highest of the negotiated fees is not an Allowable Expense.
- If one coordinating plan determines benefits on the basis of an Allowed charge amount and the other coordinating plan provides benefits or services on the basis of negotiated fees, the primary plan's payment arrangement is the Allowable Expense for all plans.
- When benefits are reduced by a primary plan because a covered individual did not comply with the primary plan's provisions, such as the provisions related to required Preauthorizations in this Plan and similar provisions in other plans, this Plan will also include the amount of those reductions in its determination of Allowable Expense when it pays second.

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

Coordination of Benefits With Medicare

Coordination with Medicare Parts A and B for you (the Employee)

This Plan is primary—and you file claims with this Plan first—if:

- You are covered under the Plan because of your current employment status, or
- You are eligible for Medicare because you have end-stage renal disease (ESRD) unless you became eligible for Medicare due to age or Disability prior to becoming eligible for Medicare due to ESRD, and the Plan is already paying secondary because you are not covered on the basis of your current employment status.

  In general, the Plan remains primary for the first 30 months if either (1) ESRD is the initial reason for Medicare-eligibility, or (2) Medicare eligibility is initially due to age or Disability and the Plan has already been paying on a primary basis because coverage is provided by virtue of current employment status. At the end of the 30-month period, Medicare will be primary.

Medicare is primary —and you file claims with Medicare first—if you do not have ESRD and you are not in "current employment status."

"Current employment status" means an individual is actively working, or is not actively working and:

- Is receiving Employer-provided Disability benefits that are subject to FICA taxation (i.e., the first six months of Disability benefits); or
- Retains employment rights in the industry (for example, as a seasonal Employee), has not had membership in an Employee organization terminated, has group health plan coverage other than COBRA coverage, is not receiving Social Security Disability benefits, and has not received Disability benefits from an Employer for more than six months.

If you elect Medicare as the primary plan, benefits under this Plan will end.

Coordination with Medicare Part A and B for your Dependents

If your Dependent (excluding Domestic Partners, see below) is eligible to receive Medicare benefits—***whether or not, he or she has actually applied for Medicare benefits***—the following rules apply:

The Plan is primary, and you or your Dependent file your Dependent's claims with the Plan first, if:

- Your Dependent is eligible for Medicare due to age or disability and is covered under the Plan because of your current employment status, or
- Your Dependent is eligible for Medicare due to ESRD, **unless**:
  - Your Dependent becomes eligible for Medicare due to age or Disability before becoming eligible for Medicare benefits due to ESRD, and
  - The Plan is already permissibly paying secondary because your Dependent is not covered on the basis of your current employment status.

    The Plan is primary payer for the first 30 months your Dependent is eligible for Medicare due to ESRD; at the end of the 30-month period, Medicare will be the primary payer.

Medicare is primary, and you or your Dependent file your Dependent's claim's with Medicare first, if:

- your Dependent does not have ESRD and you are not in current employment status.
- your Dependent may elect Medicare as the primary plan; if he or she does, benefits under the Plan will end.

Coordination with Medicare Part A and B for your Domestic Partner

The Plan is primary -- and you or your Domestic Partner file your Domestic Partner's claims with the Plan first if:

- Your Domestic Partner is eligible for Medicare due to disability and is covered under the Plan because of your current employment status, or
- Your Domestic Partner is eligible for Medicare due to ESRD. The Plan is primary for the first 30 months your Spouse is eligible for Medicare due to ESRD; at the end of the 30-month period, Medicare will be the primary payer.

Medicare is primary -- and you or your Domestic Partner file your Domestic Partner's claims with Medicare first if:

- Your Domestic Partner is eligible for Medicare due to age. (However, if your Domestic Partner has coverage through his or her own active employment, generally his/her plan would be primary and Medicare would be secondary.)

Note: If you or your Domestic Partner is enrolled in COBRA Continuation Coverage, and is or becomes eligible for Medicare, the Plan will pay secondary regardless of whether you or your Dependent has actually enrolled in Medicare.

Coordination with Government and Other Programs

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

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

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

   If an eligible individual under this Plan is covered for loss of earnings by both this Plan and any motor vehicle coverage that is required by law, including no-fault, uninsured motorist or underinsured motorist, the benefits payable by this Plan **on account of disability** will be reduced by the benefits available to you for loss of earnings pursuant to the motor vehicle coverage.

D. **Indian Health Services (IHS):** If an individual is covered by both this Plan and Indian Health Services, this Plan pays first and Indian Health Services pays second.

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

Right of Recovery Against Third Parties

If the Fund pays claims for expenses incurred because of an Illness or injury for which a third party is (or may be) responsible, **by submitting the claim for payment you (and a covered Dependent if he or she suffers the Illness or injury) are deemed to agree to each of the following conditions:**

- The Fund holds an equitable lien on any recovery received by you (or your Dependent, legal representative or agent).

- You will notify any third party responsible for your Illness or injury of the Fund's right to reimbursement for any claims related to your Illness or injury.
- You will hold any reimbursement or recovery received by you (or your Dependent, legal representative or agent) in trust on behalf of the Fund to cover all benefits paid by the Fund with respect to such Illness or injury and to reimburse the Fund promptly for the benefits paid, even if you are not fully compensated ("made whole") for your loss.
- The Fund has the right of first reimbursement against any recovery or other proceeds of any claim against the other person (whether or not the Participant or Dependent is made whole) and that the Fund's claim has first priority over all other claims and rights.
- You will reimburse the Fund in full up to the total amount of all benefits paid by the Fund in connection with the Illness or injury from any recovery received from a third party, regardless of whether the recovery is specifically identified as a reimbursement of medical expenses. All recoveries from a third party, whether by lawsuit, settlement, insurance or otherwise, must be turned over to the Fund as reimbursement up to the full amount of the benefits paid.
- The Fund's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise.
- In the event you elect not to pursue your claim(s) against a third party, the Fund shall be equitably subrogated to your right of recovery and may pursue your claims.
- You will assign, upon the Fund's request, any right or cause of action to the Fund.
- You will not take or omit to take any action to prejudice the Fund's ability to recover the benefits paid and to cooperate in doing what is reasonably necessary to assist the Fund in obtaining reimbursement.
- You will cooperate in doing what is necessary to help the Fund recover the benefits paid or in pursuing any recovery including timely submission of the Fund's third party lien form and Accident questionnaire.
- You will forward any recovery to the Fund within ten days of disbursement by the third party or will notify the Fund as to why you are unable to do so.
- You will permit the entry of judgment against you and, if applicable, your Dependent, in any court for the amount of benefits paid on your or your Dependents' behalf with respect to the Illness or injury to the extent of any recovery or proceeds that were not turned over as required and for the cost of collection, including but not limited to the Fund's attorney's fees and costs.

If you or your Dependents have uninsured motorist or under-insured motorist coverage under an automobile liability insurance policy that applies to an Illness or injury caused or contributed to by a third party, the conditions described above also apply to your rights under that insurance policy.

If you or your Dependents fail or refuse to assist Fund representatives in recovering damages from a third party, then the Fund may:

- Offset what is paid on your and/or your Dependents' future benefits claims until the Fund is completely reimbursed for the cost of these claims, including but not limited to costs incurred in collection,
- File a lawsuit against you or your Dependents to fully recover the amount the Fund should have been reimbursed, and/or
- Take any other action deemed appropriate by the Board of Trustees.

If you or your Dependents do not receive payments from a third party to reimburse the Fund for an Illness or injury caused by the third party, you do not have to pay the Fund back for any benefits properly paid to you or your Dependents. If you do receive payment from the third

party, you do not have to pay the Fund *more* than the amount the third party paid to you or your Dependents.

If you have questions about how to meet these third party liability rules, contact the Fund Administrator.

Overpayment of Benefits

The Fund reserves the right to recover claim payments made on your or your Dependents' behalf if the Fund has overpaid a claim. If the Fund makes an overpayment, you or your Dependent are obligated as a condition of coverage under the Fund to reimburse the Fund for the amount of the overpayment. The Fund may recover the overpaid amount by making deductions from any future benefit payments payable to you or assigned by you or by taking appropriate legal action.

Workers' Compensation

Benefits are not payable for any injury, Illness, disease or other physical or psychiatric condition and/or death caused by or resulting from any employment, occupation or work for wage or profit. If you incur such a loss, you should file a workers' compensation claim with your Employer. However, the Fund may provide provisional coverage subject to a lien on any workers' compensation benefits awarded. This provisional coverage is subject to the terms and conditions described above under the heading "Right to Recovery Against Third Parties."

In the event your workers' compensation claim is denied by your Employer, you must appeal the denial through your Employer's workers' compensation carrier. The Appeals Board will then issue an application for adjudication.

For your claim to be considered for payment under the Plan you must submit a copy of the denial letter and the application for adjudication to the Fund. A notice and request for allowance of lien will then be issued for signature for the charges that were submitted to the Fund for medical services rendered as a result of the alleged workers' compensation injury or Illness. Upon receipt of the executed request for allowance of lien, payment will be made on the pending claims and the Fund will file the lien claim with the Workers' Compensation Appeals Board.

If You Claim Coverage for Someone Who Is Not Eligible

If you claim coverage for a Dependent or other person who does not meet the Plan's eligibility requirements, the Fund reserves the right to take any legally permissible actions to recover any amounts wrongly paid, including withholding payment on future claims submitted by you and/or your eligible Dependents, filing a lawsuit against you and/or any person who has wrongfully received benefits and retroactively terminating the coverage for the ineligible Dependent. The Fund will withhold benefit payments for covered expenses until it has fully recovered the amount paid for expenses incurred by ineligible Dependents. The Fund shall also be entitled to recover its costs of recovery of any amounts wrongly paid, including its attorney fees and court costs. Anyone who submits a claim for a person who is not eligible should be aware that insurance fraud is a crime subject to criminal prosecution. The Trustees may also, in their sole discretion, terminate the participation of anyone found to have willfully defrauded the Fund as this is not considered to be an impermissible rescission of benefits.

COBRA: TEMPORARY CONTINUATION OF HEALTH COVERAGE

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus Reconciliation Act of 1985 (commonly called COBRA), eligible Employees, and their covered Dependents (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of their group health coverage ("COBRA Continuation Coverage") under the Plan when that coverage would otherwise end because of certain events (called "Qualifying Events" by the law). COBRA-like continuation coverage is available to Domestic Partners and their children to the same degree and in the same manner as continuation coverage is available to Spouses and step-children.

Other Health Coverage Alternatives to COBRA

Note that you may also have other health coverage alternatives to COBRA available to you that can be purchased through the **Health Insurance Marketplace**. Also, in the Marketplace you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased coverage. Being eligible for COBRA does not limit your eligibility for coverage for a tax credit. For more information about the Health Insurance Marketplace, visit www.healthcare.gov or www.coveredca.com for California residents.

You may qualify for a special enrollment opportunity for another group health plan for which you are eligible (such as a Spouse's plan), if you request enrollment in that plan within 30 days from the date your coverage under this Plan ended, even if that plan generally does not accept late enrollees.

Qualified Beneficiaries who elect COBRA Continuation Coverage must pay for it at their own expense.

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

IMPORTANT:
This chapter serves as a notice to summarize your rights and obligations under COBRA Continuation Coverage. It is provided to all covered Employees, and their covered Dependents and is intended to inform them (in a summary fashion) about COBRA coverage, when it may become available and what needs to be done to protect the right to receive COBRA coverage. 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 Dependents take the time to read this chapter carefully and be familiar with its contents.

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

Each Qualified Beneficiary **has an independent right to elect COBRA** Continuation Coverage when a Qualifying Event occurs, **and** as a result of that Qualifying Event that person's health care coverage ends, either as of the date of the Qualifying Event or as of some later date. Covered Employees may elect COBRA on behalf of their Spouses and covered parents/Legal Guardians 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 and Open Enrollment.

1. **"Qualified Beneficiary"**: Under the law, a Qualified Beneficiary is any Employee or the Spouse or Dependent Child of an Employee who is covered by the Plan when a Qualifying Event occurs, and who is therefore entitled to elect COBRA Continuation Coverage. A child who becomes a Dependent Child by birth, adoption or placement for adoption with the covered Qualified Beneficiary during a period of COBRA Continuation Coverage is also a Qualified Beneficiary. Domestic partners and their children are also considered to be Qualified Beneficiaries.

- A child of the covered Employee who is receiving benefits under the Plan because of a Qualified Medical Child Support Order (QMCSO), during the Employee's period of employment, is entitled to the same rights under COBRA as an eligible Dependent Child.
- A person who becomes the new Spouse of an existing COBRA Participant during a period of COBRA Continuation Coverage may be added to the COBRA coverage of the existing COBRA Participant but is not a "Qualified Beneficiary." This means that if the existing COBRA Participant dies or divorces before the expiration of the maximum COBRA coverage period, the new Spouse is not entitled to elect COBRA for him/herself.

2. **"Qualifying Event":** Qualifying Events are those shown in the chart below. Qualified Beneficiaries are entitled to COBRA Continuation Coverage when Qualifying Events (which are specified in the law) occur, **and**, as a result of the Qualifying Event, coverage of that Qualified Beneficiary ends. **A Qualifying Event triggers the opportunity to elect COBRA when the covered individual LOSES health care coverage under this Plan**. If a covered individual has a Qualifying Event but, as a result, **does not lose** their health care coverage under this Plan, (*e. g*. Employee continues working even though he or she becomes entitled to Medicare) then COBRA is not available.

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

Qualifying Event Causing Health Care Coverage to End	Duration of COBRA for Qualified Beneficiaries[1]		
	Employee	Spouse/ Domestic Partner	Dependent Child(ren)
You terminate employment (for other than gross misconduct), including retirement.	18 months	18 months	18 months
Your work hours are reduced such that you do not meet the service requirements under the Collective Bargaining Agreement necessary to require your Employer to make the monthly health coverage Contribution on your behalf (for example, the labor agreement requires a Contribution after you work 80 hours or more in a month but you only work 60 hours).	18 months	18 months	18 months
You die	N/A	36 months	36 months
You become divorced	N/A	36 months	36 months
Dependent Child ceases to have Dependent status.	N/A	N/A	36 months

When a covered Employee's Qualifying Event (e.g. termination of employment or reduction in hours) occurs within the 18-month period after the Employee becomes entitled to Medicare (entitlement means the Employee is eligible for and enrolled in Medicare), the Employee's covered Spouse and Dependent Children who are Qualified Beneficiaries (but not the Employee) may become entitled to COBRA coverage for a maximum period that ends 36 months after the Medicare entitlement.

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 once your COBRA Continuation Coverage ends, even if you continue COBRA for the maximum time available to you.

Maximum Period of COBRA Continuation Coverage

The maximum period of COBRA Continuation Coverage is generally either 18 months or 36 months, depending on which Qualifying Event occurred, measured from the date the Qualifying Event occurs. The 18-month period of COBRA Continuation Coverage may be extended for up to 11 months under certain circumstances (described in the section of this chapter regarding extending COBRA in cases of disability). The maximum period of COBRA coverage may be cut short for the reasons described in the section on "Early Termination of COBRA Continuation Coverage" that appears on page 85.

Medicare Entitlement

Entitlement Due to Age

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.

Entitlement Due to Disability

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.

Procedure for Notifying the Plan of a Qualifying Event

To elect COBRA Continuation Coverage after loss of coverage due to a divorce, or a child ceasing to be a "Dependent Child" under the Plan, **you and/or a family member must inform the Plan in writing of that event no later than 60 days after that Qualifying Event occurs.**

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

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

Your Employer should notify the Fund Administrator of an Employee's death, termination of employment, reduction in hours, or entitlement to Medicare. However, **you or your family should also promptly notify the** Fund Administrator **in writing** if any such event occurs in case there is a delay or oversight with your Employer providing the notification.

Notices Related to COBRA Continuation Coverage

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

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

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

COBRA Continuation Coverage (Coverage Provided)

If you elect COBRA Continuation Coverage, you will be entitled to the same health coverage (medical, dental and vision coverage but not life insurance, AD&D insurance, and loss of time or disability coverage) that you had when the event occurred that caused your health coverage under the Plan to end, but you or your Dependent are required to pay monthly for it. If there is a change in the health coverage provided by the Plan to similarly situated Active Employees and their families, that same change will apply to your COBRA Continuation Coverage.

Paying for COBRA Continuation Coverage (The Cost of COBRA)

Any person who elects COBRA Continuation Coverage must pay the full cost of the COBRA Continuation Coverage. The Fund is permitted to charge the full cost of coverage for similarly situated Active Employees and families (including both the Employer's and Employee's share), plus an additional 2%. If the 18-month period of COBRA Continuation Coverage is extended because of disability, the Plan may add an additional 50% applicable to the COBRA family unit (but only if the disabled person is covered) during the 11-month additional COBRA period.

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

IMPORTANT

There will be no invoices or payment reminders for COBRA premium payments. You are responsible for making sure that timely COBRA premium payments are made to Fund Administrator.

Grace Periods

The **initial payment** for the COBRA Continuation Coverage is due to the Fund Administrator no **later than 45 days** after COBRA Continuation Coverage is elected. If this payment is not made when due, COBRA Continuation Coverage will not take effect.

After the initial COBRA payment, **subsequent payments** are due on the first day of each month, but there will be **a 30-day grace period** to make those payments. If payment is not made within this 30-day time, COBRA Continuation Coverage will be canceled as of the due date. Payment is considered made when it is postmarked.

What If the Full COBRA Premium Payment Is Not Made When Due?

If the Fund Administrator receives a COBRA premium payment that is not for the full amount due, the Fund Administrator 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** if 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, your COBRA continuation coverage (and the coverage of any of your covered Dependents) will end.

If there is not a significant shortfall, the Fund Administrator will notify the Qualified Beneficiary of the deficiency 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 end of the month in which the last full COBRA premium payment was made.

Confirmation of Coverage Before Election or Payment

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

Addition of Newly Acquired Dependents

If, while you are enrolled in COBRA Continuation Coverage, you have a newborn child, adopt a child, or have a child placed with you for adoption, you may enroll that child for COBRA Continuation Coverage if you do so within 31 days after the birth, adoption, or placement for adoption. The child will be entitled to the full duration of COBRA and will be considered a Qualified Beneficiary.

If you marry while you are enrolled for COBRA, your Spouse is not a Qualified Beneficiary, but the Spouse can be added -- provided that you do so within 31 days of marriage -- for the remainder of the duration of your existing COBRA coverage.

Contact the Fund Administrator to add a Dependent.

Loss of Other Group Health Plan Coverage

If, while you are enrolled for COBRA Continuation Coverage your Spouse or Dependent loses coverage under another group health plan, you may enroll the Spouse or Dependent for coverage for the balance of the period of COBRA Continuation Coverage. The Spouse or Dependent must have been eligible but not enrolled in coverage under the terms of the Plan and, when enrollment was previously offered under the Plan and declined, the Spouse or Dependent must have been covered under another group health plan or had other health insurance coverage.

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of Employer Contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or Participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or Dependent within 31 days after the termination of the other coverage. Call the Fund Administrator for more information.

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

If, during an 18-month period of COBRA Continuation Coverage resulting from loss of coverage because of your termination of employment or reduction in hours, you die, become divorced, dissolve your Domestic Partnership, become entitled to Medicare (Part A, Part B or both), or if a covered child ceases to be a Dependent Child under the Plan, the maximum COBRA Continuation period for the affected Spouse, Domestic Partner and/or child is extended to 36 months measured from the date of your termination of employment or reduction in hours (or the date you first became entitled to Medicare, if that is earlier.

Notifying the Plan: To extend COBRA when a second Qualifying Event occurs, you or your Qualified Beneficiary must notify the Fund Administrator in writing within 60 days of a second Qualifying Event. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice must include your name, the second Qualifying Event, the date of the second Qualifying Event, and appropriate documentation in support of the second Qualifying Event, such as divorce documents.

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

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

In no case will COBRA Continuation Coverage be extended for more than a total of 36 months.

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

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

1. This extension is available only if:
   - the Social Security Administration determines that the individual's disability began at some time before the 60th day of COBRA Continuation Coverage; **and**
   - the disability lasts until at least the end of the 18-month period of COBRA Continuation Coverage.

Notifying the Plan: you or another family member need to notify the Plan by sending a written notification to the Fund Administrator of the Social Security Administration determination within 60 days after that determination was received by you or another covered family member. Failure to notify the Plan in a timely fashion may jeopardize an individual's rights to extended COBRA coverage. The written notice must include your name, the name of the disabled person, the request for extension of COBRA due to a disability, the date the disability began and appropriate documentation in support of the disability including a copy of the written Social Security Administration disability award documentation, **and** that notice must be received by the Fund Administrator before the end of the 18-month COBRA Continuation period.

2. The cost of COBRA Continuation Coverage during the additional 11-month period of COBRA Continuation Coverage may be 50% higher than the cost for coverage during the first 18-month period.

3. The Fund Administrator must also be notified within 30 days of the determination by the Social Security Administration that you are no longer disabled.

Early Termination of COBRA Continuation Coverage

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

1. The date the premium payment amount due for COBRA coverage is not paid in full and on time;
2. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;

3. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled Beneficiary is determined by the Social Security Administration to no longer be disabled;
4. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA Participants under the Plan).
5. The date your Employer terminates its participation in the Plan and its Active Employees are enrolled in another group health plan (e.g. if this Plan is replaced with another plan),
6. The date the Fund no longer provides group health coverage to any of its Employees.

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

Once COBRA coverage terminates early it cannot be reinstated.

California Cal-COBRA Rights

If you live in California and are enrolled in the fully insured Kaiser HMO, you can extend coverage beyond the 18 or 29 months permitted under federal COBRA under "Cal-COBRA". California law requires HMOs in the state to offer qualified beneficiaries who exhaust their 18 or 29 months of federal COBRA an additional period of continuation coverage, to a total of 36 months from the date federal COBRA began. **This state law requirement does not apply to the self-insured Bay Area Delivery Drivers Medical Plan and is only available to individuals who have elected insured Kaiser HMO coverage**. Therefore, your decision to choose the Medical Plan or Kaiser will affect your right to continuation coverage. However, because federal COBRA beneficiaries generally have the same enrollment rights as Active Employees, you may be able to switch to an HMO even after you elect COBRA coverage to take advantage of these state rights. Cal-COBRA coverage may be subject to a higher monthly cost than federal COBRA coverage.

Entitlement to Convert to an Individual Health Plan after COBRA Ends

Kaiser HMO

At the end of the 18-month or 36-month period of COBRA Continuation Coverage, you will be allowed to enroll in a Kaiser individual conversion health plan, if that right is offered by the Plan at the time your COBRA Continuation Coverage period runs out. **However, no conversion rights are available for the dental or vision coverage.** You will be advised if conversion rights are available when your COBRA Continuation Coverage ends and notified of the timeframe in which you must request to convert to an individual health plan.

Self-Funded PPO Plan

There is no opportunity to convert to an individual health plan after COBRA ends under the self-funded PPO Plan.

Notice of Medi-Cal Health Insurance Premium Program (HIPP)

If you are eligible for Medi-Cal, you may qualify for the Health Insurance Premium Payment Program (HIPP). Under this program the California Department of Health Care Services will pay your COBRA premium for you. To find out more information about HIPP including whether or not you are eligible please contact HIPP directly by email at HIPP@dhcs.ca.gov or fax at 916-440-5676.

Withdrawal of a Contributing Employer

Loss of eligibility because your Employer or former Employer leaves the Fund is **not** a COBRA Qualifying Event. However, if you or your Dependents are already on COBRA when your former Employer stops contributing to the Fund, you may continue your coverage under COBRA to the end of your continuation period (i.e., 18 months, 36 months) or until the Active Employees formerly covered by this Fund are enrolled in a new Plan. At that point your COBRA Continuation Coverage will be terminated under this Plan since your former Employer is required to provide COBRA Continuation Coverage for you and/or your Dependents under its new plan for "similarly situated" Active Employees.

Trade Adjustment Assistance Reform Act

Certain individuals may be eligible for a Federal income tax credit that can help with qualified monthly premium payments through 2019. The Health Coverage Tax Credit (HCTC), is a refundable tax credit to pay for specified types of health insurance coverage (including COBRA continuation coverage).

You may be eligible If you are a Plan Participant and have lost your job due to the negative effects of global trade or are receiving pension payments from the Pension Benefit Guaranty Corporation (PBGC).

To find out more information about the Health Coverage Tax Credit and whether you are eligible visit IRS.gov/HCTC.

GENERAL PROVISIONS/INFORMATION REQUIRED BY ERISA

Name of the Plan

The name of this Fund is the Bay Area Delivery Drivers Security Fund.

Plan Administrator/Plan Sponsor

The Bay Area Delivery Drivers Security Fund is administered by the Board of Trustees, which contracts with Health Services & Benefit Administrators (HS&BA) for administrative services. You may write to the Board of Trustees at the following address:

Bay Area Delivery Drivers Security Fund
4160 Dublin Blvd., Ste 400
Dublin, CA 94568-7756

A complete list of the Employers and Employee organizations sponsoring the Plan may be obtained by Participants upon written request to the Plan Administrator, and is available for examination by Plan Participants.

Type of Plan

The Fund is an Employee welfare benefit Fund and provides medical, dental, vision, Prescription Drug, mental health, alcohol and chemical dependency treatment and life insurance benefits for eligible Employees and Dependents, plus accidental death and dismemberment and weekly disability benefits for eligible Employees. The benefits are funded and maintained through monthly Contributions from participating Employers paid on behalf of eligible Employees and their covered Dependents pursuant to a Collective Bargaining Agreement.

Future of the Fund

The Fund and all of the Plans it sponsors are established and maintained through the collective bargaining process. The Board of Trustees anticipates that the Plan under which you are covered will continue as long as the Collective Bargaining Agreements so provide or until the Trustees decide to end the Plan or the Fund.

Subject to any maintenance of benefits requirements contained in the applicable Collective Bargaining Agreements, the Board of Trustees reserve the right to change or discontinue any Plan at any time for any reason without need for prior approval by any person, Employer or union. Such amendments may change benefit levels, eligibility requirements or any other provision of the Plan.

The Board of Trustees may update the Plan to reflect changes in laws and regulations as well as for other reasons. Any changes to the Plan will not lower amounts already payable for claims incurred before the Plan changes become effective.

Federal law prohibits use of Fund assets for any purpose other than providing benefits and paying the reasonable administrative expenses of the Fund and the Plans it sponsors. If the Fund or Plan(s) end, the remaining assets will continue to provide Plan benefits until there are no more assets left, or will be used in a way that is consistent with the purpose of the Plan or the Fund.

In no event will termination of the Plan and Trust result in the reversion of trust assets to any Employer.

Benefits and Source of Benefits

All of the benefits provided by the Plan are summarized in this document. The complete terms of the benefits provided are set forth in the group insurance policies or service agreements with the following organizations:

- Kaiser Foundation Health Plan, Inc.;

- Vision Service Plan ("VSP");
- OptumRx;
- Teamsters Assistance Program of Northern California ("TAP"); and
- ReliaStar Life Insurance Company.

Contributions to the Plan are made by Employers in accordance with their Collective Bargaining Agreements with the participating local unions and by certain other Employers pursuant to the provisions of the Trust Agreement.

There is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts the Trust Fund collected and has available for health care benefits by payment of premiums for the coverage provided by any HMO or insurer.

Agent for Service of Legal Process

Jeffrey Chapman is designated by the Board of Trustees as the Agent of the Trust Fund for the service of legal process, and can be reached at the same address as the Fund Administrator, 4160 Dublin Blvd., Ste 400, Dublin, CA 94568-7756.

Legal process may also be served on any Trustee.

Plan Trustees

The Trustees of the Plan as of the Bay Area Delivery Drivers Security Fund as of January, 2018 are:

Management Trustees	Labor Trustees
Frank Cademarti UPS 2222 17th Street San Francisco, CA 94106	Jack Bookter P.O. Box 130 El Granada, CA 94018
Steve Boulton UPS 705 Massman Dr. Nashville, TN 37210	Dennis Hart Teamsters Local 853 7750 Pardee Lane Oakland, CA 94621
Leslie Rea 411 Bark Drive Redwood City, CA 94065	Richard Rodriguez 37 Brentwood Avenue San Francisco, CA 94127

Collective Bargaining Agreements

This Plan is maintained under several Collective Bargaining Agreements providing for Contributions under the Plan. Copies of any such agreement may be obtained by Plan Participants upon written request to the Plan Administrator, and is available for examination by Plan Participants.

Assignment of benefits

Except as authorized by federal law, your benefits under the Fund cannot be assigned and are not subject to garnishment or attachment.

Information about taxes

The Plans described in this SPD provide benefits to eligible Employees and retirees in keeping with federal law and governing documents. With the exception of benefits provided to Domestic Partners, it is intended that the value of coverage generally be non-taxable for federal income tax purposes.

Right to Examine Person and Records

The Fund, at its own expense, shall have the right and opportunity to examine the medical records and person of any Participant when and as often as it may reasonably require while a claim is pending, and also reserves the right and opportunity to conduct an autopsy in case of death where it is not forbidden by law. Proof of claim forms, as well as other forms, and methods of administration and procedure will be solely determined by the Fund.

Administration of the Trust Fund

The Bay Area Delivery Drivers Security Fund is administered by the Board of Trustees, which contracts with Health Services Benefit Administrators for administrative services. You may write to the Board of Trustees at the following address:

Bay Area Delivery Drivers Security Fund
4160 Dublin Blvd., Ste 400
Dublin, CA 94568-7756

Fund Assets

The assets of the Fund are held in trust for the sole purpose of funding benefits and paying the costs of administration of the Fund and its Plans. In no event will Fund assets revert to Contributing Employers.

Trust Fund Records/Plan Year

The financial and claim experience records of the Fund are kept on a fiscal year basis, ending July 31st of each year.

Employer Identification Number and Plan Number

The Fund's Employer Identification Number is: 94-6072965. The Plan Number is 501.

Funding and Contributions

The Fund is funded by monthly Contributions from participating Employers paid on behalf of eligible Employees and their eligible Dependents covered under Collective Bargaining Agreements with participating local unions that provide for participation in the Fund.

The Employer Contribution is determined by the Board of Trustees under the authority of the Bay Area Delivery Drivers Security Fund Agreement and Declaration of Trust and the Collective Bargaining Agreements providing for Contributions to the Trust Fund.

In certain circumstances, Employees may be able to self-pay for a period of time when they are not covered by Employer Contributions.

Life and Accidental Death and Dismemberment benefits and Survivor benefits are insured through a contract with ReliaStar Life Insurance Company. Vision benefits are self-funded with a network claims administrator (contract with Vision Services Plan), Prescription Drug benefits are self-funded and paid through a contract with OptumRx, and. benefits related to the treatment of substance abuse benefits are self-funded. HMO benefits are insured through the Kaiser Permanente HMO plan. All other benefits are funded directly by the Trust Fund.

Fund assets are held in trust for the sole purpose of funding Plan benefits and paying the costs of Plan and Trust administration

Plan benefits are not guaranteed and there is no liability on the part of the Board of Trustees to provide payment over and above the amounts collected and available for such purposes. The Trustees reserve the right to change or discontinue the types and amounts of benefits described in this booklet and the eligibility rules in any manner in which they, in their sole discretion, determine to be prudent. The nature and amount of Plan benefits are always subject to the actual terms of the Plan as it exists at the time the claim occurs.

The benefits available to Active Employees and retired Employees may be changed or eliminated at any time by action of the Trustees.

Authority of the Board of Trustees/Claims Review Fiduciary

The Trust Agreement gives the Board of Trustees the authority to make any determination of fact necessary and proper to the administration of the Fund and the Plans. It also gives the Board of Trustees the power to construe and interpret the rules of the Plan and the Trust Agreement relating to eligibility of covered Employees, their Dependents and beneficiaries to receive benefits.

The Trustees shall have the exclusive right, power and authority in their sole and absolute discretion to administer, apply, interpret and/or terminate any provisions of the Plan, this Summary Plan Description/Plan Document and to decide all matters arising in connection with the operation or administration of the Plan. Without limiting the foregoing, the Trustees shall have the sole and absolute discretionary authority:

- to take all actions and make all decisions with respect to eligibility for, and the amount of, benefits payable under the Plan;
- to formulate, interpret and apply rules, and policies necessary to administer the Plan in accordance with its terms;
- to decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan;
- to resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents; and
- to process, and approve or deny, benefit claims, and rule on any benefit exclusions.

All determinations made by the Trustees with respect to any matter arising under the Plan, this Summary Plan Description/Plan Document shall be final and binding on all parties.

ONLY THE FULL BOARD OF TRUSTEES IS AUTHORIZED TO INTERPRET THE PLAN OF BENEFITS DESCRIBED IN THE BOOKLET AND NO INDIVIDUAL TRUSTEE, UNION REPRESENTATIVE OR EMPLOYER REPRESENTATIVE IS AUTHORIZED TO INTERPRET THIS PLAN ON BEHALF OF THE BOARD OR TO ACT AS AN AGENT OF THE BOARD.

THE BOARD OF TRUSTEES HAVE AUTHORIZED THE FUND ADMINISTRATOR TO RESPOND IN WRITING TO WRITTEN INQUIRIES FROM PLAN PARTICIPANTS AS A CONVENIENCE TO PARTICIPANTS, THE FUND ADMINISTRATOR WILL PROVIDE ORAL ANSWERS REGARDING COVERAGE ON AN INFORMATIONAL BASIS. HOWEVER, NO SUCH ORAL COMMUNICATION IS BINDING UPON THE BOARD OF TRUSTEES.

The Board of Trustees have full authority to determine matters arising under self-funded benefits in the chart below:

Type Of Benefit	Name Of Provider	Type of Funding
Indemnity Medical Plan	Fund Administrator for BADD	Self-Funded
Prescription Drugs	OptumRx	Self-Funded
Alcohol/Chemical Dependency benefits for the medical PPO Plan	If enrolled in Indemnity Medical Plan: Teamsters Assistance Plan (TAP)	Self-Funded

Type Of Benefit	Name Of Provider	Type of Funding
Dental	Fund Administrator BADD	Self-Funded
Vision	Visions Service Plan	Self-Funded
Short-term Disability	Fund Administrator BADD	Self-Funded

Trustees have delegated their authority to determine matters arising under insured benefits in the chart below.

Type Of Benefit	Name Of Provider	Type of Funding
HMO medical benefits	Kaiser Permanente	Insured
Life, AD&D, Survivor Income	ReliaStar Life Insurance Co.	Insured

Contribution Source

The benefits provided under the Bay Area Delivery Drivers Security Fund are financed entirely by Contributions from Employers in accordance with the Collective Bargaining Agreement between the Employers and the participating local unions. The amount of the Contributions is determined through the collective bargaining process.

Statement of ERISA Rights

As a Participant in the Bay Area Delivery Drivers Security Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Fund Administrator all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration).
2. Obtain, upon written request to the Plan Administrator, copies of documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administrator may make a reasonable charge for the copies.
3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

1. Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the COBRA chapter. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

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

Assistance with Your Questions

1. If you have any questions about your Plan, you should contact the Fund Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, 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, DC 20210.
2. You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration (formerly known as the Pension and Welfare Benefit Administration) at Toll-Free: 1.866.444.EBSA (3272).

Nondiscrimination Statement

The Bay Area Delivery Drivers Security Fund complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. The Bay Area Delivery Drivers Security Fund does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

The Bay Area Delivery Drivers Security Fund:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact Jeff Chapman at (800) 654-1824 or (925) 833-7300.

If you believe that the Bay Area Delivery Drivers Security Fund has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, D.C. 20201
1-800-868-1019, 800-537-7697 (TDD)

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 1-(800) 654-1824.

注意： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電1-(800) 654-1824.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số: 1-(800) 654-1824.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wikanang walang bayad. Tumawag sa (800) 654-1824).

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.

(800) 654-1824 번으로 전화해 주십시오.

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝

Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք (հեռատիպ) (800) 654-1824):

تماس دیری‌شما.بگ یبرا گانی‌بصورت را یزبان لاتی‌تسه، دیکن یگفتگو م یتوجه: اگر به زبان فارس
1- (800) 654-1824) ف یبا. باشد م

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните (800) 654-1824 (телетайп: 1-xxx-xxx-xxxx).

注意事項： 日本語を話される場合、無料の言語支援をご利用いただけます。(800) 654-1824）まで、お電話にてご連絡ください。

ملحوظة: إذا كنت تتحدث اللغة اذكر، فإن خدمات المساعدة اللغوية تتوافر لك.
هـ الصم والبكم: رقم (800) 654-1824 برقم اتصل .بالمجان

ਿਧਆਨ ਿਦਓ: ਜੇ ਤੁਸ~ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤ~ ਭਾਸ਼ਾ ਿਵੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। (800) 654-1824 'ਤੇ ਕਾਲ ਕਰੋ।

ប្រយ័ត~៖ េបើសិន~អ~កនិ~យ ~~ែខ~ រ, េស~ជំនួយែផ~ក~~ េ~យមិនគិតឈ~ ~ល គឺ~ច~នស់~ប់បំេ~រអ~ក។ ចរ ទរស័ព(800) 654-1824។

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau (800) 654-1824.

ียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร (800) 654-1824.

注意： 如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 1-800-654-1824.

HIPAA: Use and Disclosure of Protected Health Information

Your Health Information and Privacy

The health benefit options offered under the Fund use health information about you and your covered Dependents only for the purposes of providing treatment, paying claims, and related functions. A copy of the Fund's Privacy Notice appears below.

To protect the privacy of health information, access to your health information is limited to such purposes. Effective **April 14, 2003**, the health benefit plan options offered under the Fund will comply with the applicable health information privacy requirements in Title II of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and the applicable federal regulations issued by the Department of Health and Human Services. Specific procedures related to the security of electronically transmitted Protected Health Information ("ePHI") effective April 20, 2005, are also described below.

Privacy Notice

Use and Disclosure of Health Information

The Fund may use your health information, that is, information that constitutes protected health information as defined in the Privacy Rule of the Administrative Simplification provision of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Fund may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Fund may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

The Fund may also disclose health information over the telephone to your Spouse, another family member, or a personal representative (such as a union business agent or Employer representative), for purposes of making or obtaining information about treatment or claims if you provide your oral authorization to the Fund to speak to this person on your behalf. If you do not wish the Fund to release your health information to your Spouse, family member or personal representative without prior *written* authorization, please follow the instructions under the Right to Make Restrictions found in this notice.

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Fund and as necessary to provide coverage and services to all Plan Participants. For example, the Fund may use your health information to

conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment. The Fund does not provide treatment. However, the Fund may use or disclose your health information to support treatment and the management of your care. For example, the Fund may disclose that you are eligible for benefits to a health care provider who contacts the Fund to verify your eligibility.

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

For Distribution of Health-Related Benefits and Services. The Fund may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

Public Health Risks. The Fund may disclose medical information about you for public health activities. These activities generally include the following:

- Prevention and control of disease, injury or disability.
- Reporting of births and deaths.
- Reporting child abuse or neglect.
- Reporting reactions to medications or problems with products.
- Notifying people of recalls of products they may be using.
- Notifying a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- Notifying the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

For Disclosure to the Plan Sponsor. The Plan sponsor represents that adequate separation exists between the Plan and Plan sponsor so that Protected Health Information (PHI) will be used only for Plan administration. As a jointly trusteed multiemployer trust fund which contracts with a third party administrator, the Plan sponsor has no Employees. No person under the control of the Plan sponsor has access to your PHI. The Fund may disclose your health information to the Plan sponsor for Plan or Fund administration functions performed by the Plan sponsor on behalf of the Fund and Plans. Such administration shall include, but is not limited to, the following purposes: appeals of adverse benefit determinations, financial oversight, data analysis, COBRA administration, coordination of benefits, and Plan design. The Fund also may provide summary health information to the Plan sponsor so that the Plan sponsor may solicit premium bids from other health Plans or modify, amend or terminate the Plan.

As a condition for obtaining PHI from the Fund and other insurers and HMOs participating in the Plan, the Plan sponsor agrees to:

- Use or disclose any PHI received from the Plan only as permitted by the Privacy Rule or as required by law.
- Require each of its subcontractors or agents to whom the Plan sponsor may provide PHI to agree to the same restrictions and conditions that apply to the Plan sponsor with respect to PHI.
- Bar the use or disclosure of PHI for employment-related actions or decisions or in connection with any other Employee benefit plans sponsored by the Plan sponsor.
- Report to the Fund any use or disclosure of PHI that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- Make your PHI available for purposes of your request for inspection or copying.

- Make PHI available to the Plan to permit you to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as is allowed under the Privacy Rule.
- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule.
- Make its internal practices, books and records relating to the use and disclosure of PHI available to the Fund and to the Secretary of the U.S. Department of Health and Human Services ("DHHS") for the purpose of determining the Plan's compliance with the Privacy Rule.
- If feasible, return to the Fund or destroy all PHI received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the Plan sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.
- Use best efforts to request only the minimum necessary type and amount of PHI to carry out the functions for which the information is requested.

When Legally Required. The Fund will disclose your health information when it is required to do so by any federal, state or local law.

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

To Conduct Health Oversight Activities. The Fund may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure or disciplinary action. The Fund, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not directly related to your receipt of health care or public benefits.

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

For Law Enforcement Purposes. As permitted or required by state law, the Fund may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Fund has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Coroners, Medical Examiners and Funeral Directors. The Fund may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Fund may also release your health information to funeral directors as necessary to carry out their duties.

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

For Specified Government Functions. In certain circumstances, federal regulations require the Fund to use or disclose your health information to facilitate specified government functions

related to the military and veterans, national security and intelligence activities, protective services for the president and others, and correctional institutions and inmates.

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

In the Event of Your Death. If the individual is a decedent, the Fund may disclose the decedent's PHI (other than information about past, unrelated medical problems) to the decedent's family members and others who were involved in the care or payment for care of the decedent prior to the decedent's death, unless doing so would be inconsistent with any prior expressed preference of the individual that is known to the Fund.

Authorization to Use or Disclose Health Information

Other than as stated above, the Fund will not disclose your health information without your written authorization. If you authorize the Fund to use or disclose your health information, you may revoke that authorization in writing at any time.

Your Rights with Respect to Your Health Information

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

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Fund's disclosure of your health information to someone involved in the payment of your care. However, the Fund is not required to agree to your request. If you wish to make a request for restrictions, please contact the Fund's Privacy Officer. **Right to Receive Confidential Communications.** You have the right to request that the Fund communicate with you in a certain way if you feel the disclosure of your health information could endanger you. You may be required to provide a statement that disclosure of your health information could endanger you. For example, you may ask that the Fund only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Officer at the Fund Administrator. The Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Officer at the Plan Administration Office. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Fund amend the records. That request may be made as long as the Fund maintains the information. A request for an amendment of records must be made in writing to the Privacy Officer at the Fund Administrator. The Fund may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Fund, if the health information you are requesting to amend is not part of the Fund's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Fund determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Plan for any reason other than for treatment, payment or health operations. The request must be made in writing to the Fund's Privacy Officer at the Fund Administrator. The request should specify the time period for which you are requesting the information. Accounting requests may not be made for periods of time going back more than six years. The Fund will provide the first accounting you request during any 12-month period

without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Fund will inform you in advance of the fee, if applicable.

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

Duties of The Fund

The Fund is required by law to maintain the privacy of your health information and to provide to you this Privacy Notice of its duties and privacy practices. The Fund is required to abide by the terms of this Privacy Notice, which may be amended from time to time. The Fund reserves the right to change the terms of this Privacy Notice and to make the new privacy practice provisions effective for all health information that it maintains. If the Fund changes its policies and procedures, the Fund will revise the Privacy Notice and will provide a copy of the revised notice to you within 60 days of the change. You have the right to express complaints to the Fund and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Fund should be made in writing to the Fund's Privacy Officer at the Plan Administration Office. The Fund encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

Contact Person

The Privacy Officer is the contact person for all issues regarding patient privacy and your privacy rights. You may contact the Privacy Officer by calling 800-654-1824 or 925-833-7300.

Effective Date

The Fund's privacy policies and procedures became effective April 14, 2003.

SECURITY RULE

The following are the Fund's security rules with regard to the creation, receipt, maintenance, storage and transmission of Protected Health Information ("PHI") via electronic means ("ePHI").

Use and Disclosure of ePHI. The Fund and its Plans may use and disclose ePHI, including ePHI for treatment, payment and operations, and such other uses and disclosures as are permitted and required under the HIPAA Privacy Rule and Security Rule, and the representatives of the Fund shall have access to such PHI, including ePHI, as is necessary for them to perform their duties for the Fund and its Plans.

Trustees' Use and Disclosure of ePHI. To the extent permitted by law, the Trustees may receive, use and disclose ePHI, if, in the sole discretion of the Trustees, such ePHI is necessary for the Trustees to perform their fiduciary or administrative duties as Trustees. In all cases, the Trustees shall receive, use and disclose the minimum amount of ePHI necessary for the Trustee to perform their functions under the Fund, and shall safeguard such ePHI as required by the Privacy and Security Rules. Each Trustee who receives ePHI from the Fund shall keep such information in strict confidence and shall not use or further disclose the ePHI received from the Fund other than as permitted or required by law and this Agreement or upon the express written permission of the Participant who is the subject of the ePHI.

Procedures. The Fund will implement administrative, physical and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Fund, and will ensure the "adequate separation" within the meaning of 45 C.F.R. §164.504(f)(2)(iii) of the data.

DEFINITIONS

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Accident: An event that caused a physical injury; was caused by a sudden, violent, and external force; was not expected and could not have been reasonably foreseen; and could not have been avoided.

Active Employee: You are an Active Employee if your continued participation in the Plan is based on the number of hours you work for a Participating Employer bound by a Collective Bargaining Agreement with a Participating Local Union that calls for Contributions to be made to the Fund on your behalf. You remain an Active Employee if you are on leave or otherwise not actively working provided that the Collective Bargaining Agreement requires your Employer to continue to make Contributions to the Fund while you are on such leave, and such Contributions are in fact made.

Affordable Care Act or "ACA": the law passed in March 2010 (also known as the "Patient Protection and Affordable Care Act," "PPACA," and "Obamacare"). As described in this SPD, this Plan is subject to many (but not all) of the requirements of the ACA applicable to group health plans. For purposes of the ACA, this Plan is a non-grandfathered plan.

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 an In-Network provider** (PPO network Health Care or Dental Care provider/facility), the negotiated fee/rate set forth in the agreement between the participating network Health Care or Dental Care Provider/facility and the PPO network or the Plan; **or**
2. **With respect to a Non-Network (or Out-of-Network) provider**, Allowed Charge amount means the schedule that lists the dollar amounts the Plan has determined it will allow for eligible Medically Necessary services or supplies performed by Non-Network providers.

   The Plan's Allowed Charge amount list is not based on or intended to be reflective of fees that are or may be described as usual and customary (U&C), reasonable and customary (R&C), usual, customary and reasonable charge (UCR), prevailing or any similar term. The Plan reserves the right to have the billed amount of a claim reviewed by an independent medical review firm/provider to assist in determining the amount the Plan will allow for the submitted claim; or
3. For an In-Network Health Care Provider/facility whose network contract stipulates that they do not have to accept the network 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 an In-Network claim; **or**
4. The Health Care or Dental Care Provider's/facility's actual billed charge.

The Plan will not always pay benefits equal to or based on the Health Care or Dental Care Provider's actual charge for health care services or supplies, even after you have paid the applicable Deductible, 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-network 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 Required Preauthorizations, Claims Administrator, attorney, stop loss carrier, medical claim repricing firm, discount negotiation firm or wrap/secondary network. This negotiated discounted amount will become the "Allowed Charge" amount upon which the Plan will base its payment for covered services for the non-network provider considering the plan's cost-sharing provisions, In-Network/non-network 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-Network 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, 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);

You may be financially responsible for the difference between the amount billed by an out-of-network Emergency Services provider for services rendered and the amount the plan pays the Emergency Services provider (the "Allowed Charge" described above) for services rendered (known as "Balance Billing"). Please see definition of Balance Billing below for more information.

See the definition of Emergency Services in this chapter.

Balance Billing: A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Charges and what the provider actually charged (the billed charges). Amounts associated with Balance Billing **are not covered** by this Plan, even if the Plan's Out-of-Pocket Maximum is reached. See also the provisions related to the Plan's Out-of-Pocket Expenses and the Plan's definition of Allowed Charge. Remember, amounts exceeding the Allowed Charge do not count toward the Plan's Out-of-Pocket Maximum and may result in Balance Billing to you. **Non-PPO providers commonly engage in Balance Billing**. Balance billing occurs when a healthcare provider bills a patient for charges (other than copayments, coinsurance, or Deductibles) that exceed the plan's payment for a covered service. Generally, you can avoid Balance Billing by using In-Network providers. Typically, PPO providers do not balance bill except in situations of third party liability claims. **Generally, you can avoid Balance Billing by using PPO providers.**

Bay Area Delivery Drivers Security Fund: The trust established to sponsor health benefit plans pursuant to the Collective Bargaining Agreements and the Trust Agreement.

Beneficiary: The person or persons you have designated to receive certain Plan benefits that are payable if you die.

Calendar Month and Calendar Year: The 12 named months of a Calendar Year. A Calendar Year is a period that starts on January 1 and ends on December 31 of each year.

Chiropractic Treatment: Treatment provided, supervised, or directed by a licensed chiropractor (including neuromuscular physical medicine) and incurred while under the care of a chiropractor.

Collective Bargaining Agreement: The most recent Collective Bargaining Agreement between a participating Employer and Union which has been approved by the Fund's Board of Trustees.

Complications of Pregnancy: Medically necessary cesarean section; spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible; or a condition that requires Hospital confinement (when the pregnancy is not terminated) whose diagnosis is distinct from pregnancy but is caused or adversely affected by

pregnancy, such as acute nephritis, nephrosis, cardiac decompensation, missed abortion, and similar medical and surgical conditions of comparable severity.

The term "complication of pregnancy" does not include false labor, occasional spotting, Physician-prescribed rest during a pregnancy, morning sickness, pre-eclampsia, or similar conditions that are associated with a difficult pregnancy but do not constitute classifiable distinct Complications of Pregnancy.

Contributing Employer (and "Employer"): Any Employer party to a Collective Bargaining Agreement providing for health and welfare payments to the Fund, or that has executed a subscriber agreement to be bound to the terms of the Trust Agreement establishing the Bay Area Delivery Drivers Security Fund.

Contribution: The payment required to be made to the Fund by any Employer in accordance with the provisions of the Trust Agreement and applicable Collective Bargaining Agreement.

Cosmetic: Surgery or other treatment performed to alter and reshape normal body structures primarily for the purpose of improving an individual's appearance.

Custodial Care: Care that consists of services and supplies that are given mainly to help a person meet the activities of daily living, whether or not the person is disabled, and that are not rendered mainly for their therapeutic value in the treatment of an injury or disease. Custodial care includes, but is not limited to, care mainly to provide room and board, preparation of special diets, supervision of the administration of medications that can normally be self-administered, and personal care such as helping a person walk, get in or out of bed, bathe, dress, eat, or use the toilet.

Deductible: An amount of covered charges that must be incurred by a covered person before most Plan benefits will be paid.

Dentist: A Doctor of Dental Science or Doctor of Dental Surgery (DDS) or a Doctor of Dental Medicine (D.M.D.) licensed to practice Dentistry in the state, country or other jurisdiction in which he or she renders treatment.

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

Dependent Child(ren). For the purposes of this Plan, a Dependent Child is any of the Employee's/Participant's children listed below to age 26 (whether married or unmarried) including:

- Children to age 26 including:
  - ✓ your natural children;
  - ✓ your stepchildren (including children of your Domestic Partner) who live in your household;
  - ✓ legally adopted children on the date they are placed with you in your home in anticipation of final adoption;
  - ✓ children for whom you have been appointed Legal Guardianship;
  - ✓ foster children;
  - ✓ children designated as your Dependents in a valid and approved Qualified Medical Child Support Order, or for whom you have been designated as the child's Legal Guardian.
- **Adult Disabled Child:** Unmarried mentally or physically disabled children age 26 and older who are unable to support themselves and are primarily dependent on you for their support provided, (1) they were eligible and totally and permanently disabled before age 26; and (2) you furnished proof of the ongoing total and permanent disability within 31 days of your child reaching age 26 (and as may also be periodically required by the Fund after age 26).

Domestic Partner: Same-sex and opposite-sex couples registered with any state or local government agency authorized to perform such registrations. There are no requirements for proof of relationship or waiting periods that are not also applied to married couples.

Drug or Prescription Drug: Drug or Prescription Drug means medication that may be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act, including any amendments thereto, only upon a written or oral prescription of a Dentist or Physician (other than a psychologist or chiropractor) licensed by law to administer it.

Durable Medical Equipment: Equipment that is designated for repeated use, is mainly and customarily used for medical purposes, and is not generally of use to a person in the absence of a disease or injury. Durable medical equipment includes, but is not limited to, equipment such as Hospital beds, wheelchairs, iron lungs, traction apparatus, intermittent positive pressure breathing machines, braces, and crutches.

Emergency Medical Condition: An Illness or injury, symptom or condition that is sever enough (including severe pain), that if you did not get immediate medical attention you could reasonably expect one of the following to result: (1) Your health would be put in severe danger; or (2) You would have serious problems with your bodily functions; or (3) You would have serious damage to any part or organ of your body.

Emergency Services: means with respect to an Emergency Medical Condition (defined above), 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. Emergency Services includes a medical screening examination and medical treatment necessary to stabilize the person (in other words, to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from, or occur during, the transfer of the person from the facility).

Employee: Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed under a Collective Bargaining Agreement between an Employer and Union and on whose account the Employer is obligated to make, and is making, required Contributions to this Plan. Employee can also mean a non-bargaining unit Employee of an Employer who has signed a non-bargaining unit participation agreement with the Plan.

Experimental: Any accommodations, services, supplies, or other items or combination of the foregoing that are determined by the Fund Administrator to be a medical or health care procedure or treatment:

- that is not recognized as conforming to safe and accepted medical or health practice,
- in which the scientific assessment of the technique, or its application for a particular condition, has not been completed or its effectiveness established, or
- for which the required approval of a governmental agency has not been granted at the time the services are rendered.
- under investigation or limited to research: by the federal Food and Drug Administration (FDA), the American Medical Association (AMA), Diagnostic and Therapeutic Technology Assessment (DATTA), or the Office of Medical Application of Research of the National Institute of Health Office of Technology Association (OMT). However, if a treatment has not been addressed by one of the organizations listed above, the Plan may determine if a treatment is appropriate based on the advice of its medical review and/or the review of an independent medical reviewer or other medical experts.

The Fund Administrator will make such determination. To determine whether a particular accommodation, service, supply, or other item is Experimental, the Fund Administrator may review established preauthorization procedures, and refer to the current applicable literature and federal and state laws and regulations, and consider any other information it deems relevant or appropriate. Such determination will be conclusive and binding with respect to all concerned

parties. Please see page 17 for information regarding the Plan's coverage for participation in clinical trials.

Fund: The Bay Area Delivery Drivers Security Fund.

Fund Administrator: The entity that Administers the Fund's self-funded plans of benefits. The Fund Administrator is appointed by the Trustees to perform the day to day administration of the Fund and its benefit plans and regularly engages in the business of providing claims administration, adjustment and payment and claims review services to Employee welfare benefit plans. Note that the Fund Administrator does not have authority or discretion to interpret the Plans or the terms of this booklet, only the Board of Trustees has that authority. The current Fund Administrator is Health Services & Benefit Administrators (HS&BA). The Fund Administrator's address is on the Quick Reference Chart at the beginning of this SPD.

Habilitative/Habilitation: Health care services, such as Physical Therapy, occupational therapy, and/or speech-language pathology, provided to individuals with developmental delays that have never acquired normal functional abilities. Examples of Habilitative services includes Physician-prescribed therapy for a child who is not walking or talking at the expected age. Habiliative services are **not** covered under this Plan.

Health Care Practitioner: A person shown in the following list of Health Care Practitioners, but only if the person is licensed and practices within the scope of the license:

- a Dentist,
- a psychologist,
- a physical therapist,
- a speech therapist,
- a chiropractor,
- a podiatrist,
- an optometrist,
- an optician,
- a certified acupuncturist, or
- a registered Nurse (RN) or Physician's assistant (PA).

If you are receiving care from a type of provider who is not listed above and intend to make a claim for benefits for such care, please call the Fund Administrator to determine if the care is covered. See also the definition of a Physician.

To the extent required by the ACA, 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.

Generic Drugs: Prescription medication which is equivalent to a brand name Drug and meets the same Food and Drug Administration (FDA) requirements for purity, strength and safety, but is not protected by trademark registration.

Home Health Care: Services and supplies provided in lieu of the services which would have been covered if you were confined in a Hospital or convalescent Hospital, including skilled nursing care and home health aide services. Home health care does not include housekeeping or Custodial Care.

Home Infusion Therapy: Medicine taken at home through a pump or intravenously that can be maintained by the patient after specific instruction by a registered Nurse.

Hospice: An alternate type of treatment for terminally ill patients. A Hospice facility or program focuses on trying to make death less painful, less stressful, and less fearful for the patient

and his or her family. Hospices provide both home and inpatient care, including, but not limited to:

- Physician services,
- Home health care services,
- Physical therapy,
- Rental of Hospital beds, wheelchairs, and other equipment,
- Homemaker services,
- Pain control, and
- Bereavement and emotional support services for the patient's family.

Hospital: An institution that meets all of the following requirements:

- It mainly provides medical treatment to inpatients.
- It maintains facilities for diagnosis.
- It provides treatment only by or under a staff of Physicians, and has a doctor in regular attendance.
- It maintains permanent and full-time facilities for bed care of five or more resident patients.
- It provides care by registered Nurses 24 hours a day.
- It maintains permanent facilities for surgery.
- It maintains a daily medical record for each patient.
- It complies with all licensing and other legal requirements, and is operated lawfully in the jurisdiction where it is located.
- It is not a Skilled Nursing Facility or a specialized facility.
- It is not, other than incidentally,
    - a place for Custodial Care,
    - a place for the aged,
    - a place for the care of persons addicted to or dependent on a Drug or chemical, including alcohol,
    - a place of rest, rest home or convalescent home, or
    - a nursing home, a hotel, or a similar institution.

Illness: Any bodily sickness or disease, including any congenital abnormality of a newborn child, as diagnosed by a Physician and as compared to the person's previous condition.

Legal Guardianship: The term "Legal Guardianship" refers to the court-ordered relationship between a child and a person other than the legal parent resulting in the termination of parental rights and the assumption of responsibility over the child by a non-parent guardian.

Licensed Psychiatric Health Facility: An institution that meets all of the following tests:

- It mainly provides psychiatric treatment to inpatients.
- It maintains facilities for diagnosis.
- It provides treatment only by or under a staff of Physicians.
- It provides care by registered Nurses 24 hours a day.
- It maintains psychology and social work departments.
- It maintains a daily medical record for each patient.

- It complies with all licensing and other legal requirements.
- It is not, other than incidentally,
  - a place for Custodial Care,
  - a place for the aged,
  - a place for the care of persons addicted to or dependent on a Drug or chemical, including alcohol,
  - a place of rest, or
  - a nursing home, a hotel, or a similar institution.

Medically Necessary: With respect to each service and supply, the term "Medically Necessary" means that the service or supply meets all of the following tests:

- It is needed to prevent, diagnose or treat an Illness, injury condition, disease or its symptoms.
- It is appropriate for the symptoms, consistent with the diagnosis, and otherwise in accordance with generally accepted medical practice and professionally recognized standards.
- It is not mainly for the convenience of the covered person or the covered person's Physician or other provider.
- It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in an acute care Hospital or other facility, this test means that the covered person needs to be confined as an inpatient due to the nature of the services rendered or due to the covered person's condition and that the covered person cannot receive safe and adequate care through outpatient treatment.

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

Nurse: A person who is a Registered Nurse (R.N.), a Licensed Vocational Nurse (L.V.N.), or a Licensed Practical Nurse (L.P.N.).

Open Enrollment or Open Enrollment Period: The month of July, with coverage effective August 1.

Participant (or "Plan Participant"): An individual employed by a Contributing Employer on whose behalf Contributions are made to this Plan who has met the Plan's eligibility requirements.

Period of Disability (as it relates to Short Term Disability): Period of disability means the time period beginning with the first day of hospitalization or the first surgery for a particular disorder and ending with a return to work (if you are an eligible Employee). If you are a Dependent, a Period of Disablity ends when you have not been confined to an inpatient facility for a period of six months.

Periods of Disability that follow each other and are due to totally unrelated causes will be considered separate periods of disability.

Physical Therapy: The prevention and management of movement disorders arising from an Illness or injury administered by a licensed Physical Therapist pursuant to the orders of the Physician treating said Illness or injury.

Plan Administrator: The Board of Trustees for the Bay Area Delivery Drivers Security Fund.

Physician: A person licensed to practice medicine under applicable state law or doctor of osteopathy. To the extent that benefits are provided and while practicing within the scope of his/her license, Physician will not include you or your Dependents or any person who is the Spouse, parent, child, brother or sister of you or your Dependent.

Plan Year: The twelve-month period beginning each August 1 and ending July 31 of the succeeding Calendar Year.

Preventative Care: Services performed for screening purposes when the individual does not have active signs or symptoms of a condition. Preventive care does not include diagnostic tests performed because the individual has a condition or an active symptom of a condition

Professionally Recognized Standards: The term "professionally recognized standards" means professionally recognized standards of quality, as determined by the Board of Trustees for this Fund in consultation with inside or outside medical professionals with expertise in the particular area of medicine. To determine such standards, the Fund may use such groups as: The American Medical Association; the American Dental Association; their affiliates and successors; peer review groups; professional review groups; and similar groups.

Qualified Medical Child Support Order (QMCSO): Qualified Medical Child Support Order (QMCSO) means a medical support order issued by a court of competent jurisdiction or through an administrative process established under state law that has the force and effect of law under that state, and which creates or recognizes the existence of a child's right to, or assigns to a child the right to, receive benefits for which a Plan Participant is eligible. The Plan must determine that the order is qualified under the terms of ERISA and applicable state law.

Residential Treatment Program/Facility/Care: is a non-acute Hospital, intermediate inpatient setting with 24-hour level of care that operates 7 days a week, for people with behavioral health disorders including mental (psychiatric) disorders or substance use/abuse (alcohol/Drug) disorders that are unable to be safely and effectively managed in outpatient care. To be payable by this Plan, a facility must be licensed as a Residential Treatment Facility (licensure requirements for this residential level of care may vary by state).

Skilled Nursing Facility and Rehabilitation Hospital: An institution that meets all of the following tests:

- It mainly provides skilled nursing care or rehabilitation care to registered inpatients.
- It provides care that is supervised, 24 hours per day, by a Physician or a registered Nurse.
- It has available at all times a Physician who is a staff member of an acute care Hospital.
- It has a registered Nurse, licensed vocational Nurse, or licensed practical Nurse on duty 24 hours per day and has a registered Nurse on duty at least 8 hours per day.
- It maintains a daily medical record for each patient.
- It complies with all licensing and other legal requirements.
- It is not a specialized facility.
- It is not, other than incidentally,
    - a place for Custodial Care,
    - a place for the aged,
    - a place of rest, or
    - a nursing home, a hotel, or a similar institution.

Spouse: An Employee's Spouse means a person of the **opposite gender or same gender** who is legally married under State law. The following are not defined as a Spouse under this Plan: a Domestic Partner, a civil union partner, or a divorced former Spouse of an Employee, a common law marriage, or a Spouse of a Dependent Child. An ex-Spouse is not eligible even if an Employee is required by a divorce decree, court order or other legal action to continue coverage for the ex-Spouse.

Total Disability, Totally Disabled: You are Totally Disabled, or suffer from a Total Disability, when:

1) you are unable, due to Illness, injury or health complications due to pregnancy, to perform your regular and customary work, and
2) you are not working in any gainful employment.

Your Dependent is Totally Disabled, or suffers from a Total Disability, when he or she is completely unable to engage in the normal activities of a person of the same sex or age.

For purposes of COBRA extended disability coverage only, disabled means the Social Security Administration's determination of disability.

Trust Agreement: The Agreement and Declaration of Trust establishing the Bay Area Delivery Drivers Security Fund and any modification, amendment, extension or renewal thereof.

Trustees or Board of Trustees: Trustees or Board of Trustees means the Board of Trustees of the Bay Area Delivery Drivers Security Fund.

Union: A local union affiliated with the International Brotherhood of Teamsters that has entered into an agreement with a Contributing Employer which provides for the provision of benefits under the Plan.

You, your: When used in this document, these words refer to the Employee who is covered by the Plan. They do **not** refer to any Dependent of the Employee.

5531370v1/01696.001