TEAMSTERS LOCAL UNION No. 856
Health and Welfare Fund

MEDICAL BENEFITS PROGRAM

SUMMARY PLAN DESCRIPTION
PLANS AA - A - D - E

This plan is filed with the Internal Revenue Service under No. 6123582
and with the Department of Labor under No. 501 WP 193382

Revised July 1, 2023

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TEAMSTERS LOCAL UNION NO. 856
HEALTH & WELFARE FUND

Medical Benefits Program

SUMMARY PLAN DESCRIPTION

PLANS AA – A – D – E and Select Plans

For Active Employees, Retirees,
And Their Eligible Dependents

Information about the HMO and EPO benefits is available in separate Plan booklets, which are available from the Fund Office.

This plan is filed with the Internal Revenue Service
Under No. 6123582 and with the
Department of Labor under No. 501 WP 193382.

REVISED July 1, 2023

TEAMSTERS LOCAL UNION NO. 856
HEALTH AND WELFARE FUND

1000 Marina Blvd Ste 400
Brisbane, CA 94005-1841
Telephone (800) 297-4595

TO ELIGIBLE PARTICIPANTS

We are pleased to present this updated booklet describing the benefits provided by your Health and Welfare Fund, as of July 1, 2023. This booklet incorporates Plans AA, A, D, E, and the Select Plans. The plan of benefits to which you and your dependents are eligible is determined by the applicable Collective Bargaining Agreement under which you are employed.

This booklet furnishes a brief description of the benefits to which you and your family are entitled, the rules governing these benefits, the procedures that should be followed when making a claim as well as information concerning the administration of the Plan as required by the Employee Retirement Income Security Act of 1974.

This booklet also contains the eligibility rules for Retiree coverage under the Teamsters Local Union No. 856 Health and Welfare Fund and a description of the benefits which are available to eligible retirees and their dependents. It must be understood that not all collective bargaining agreements requiring contributions to the Teamsters Local Union No. 856 Health and Welfare Fund include coverage for retiree benefits. You can contact the Local Union and/or Fund Office who will be able to advise you whether or not the particular Collective Bargaining Agreement you are working under includes coverage for retiree benefits.

We encourage you to become familiar with your benefits and the valuable protection they offer. This booklet will also help you understand what services are and are not covered and special steps you need to take to receive the highest level of coverage.

The only source of authorized information is the benefit booklet and booklet inserts, if any, Trust Agreement, the Rules and Regulations and the written statements of the Fund Manager and his authorized agents located in Brisbane, California and Seattle, Washington, and legal representative located in San Francisco, California. Statements or representations made by individuals other than those designated personnel are not authoritative sources of information.

As in the past, we may find it necessary from time to time to change the provisions of the Plan by amending the Rules and Regulations. When this occurs you will be notified.

If you have any questions about your eligibility or benefits, please do not hesitate to contact the Fund Office for assistance.

Sincerely,

BOARD OF TRUSTEES

UNION	**EMPLOYER**
Julie Wall	Douglas Cornford
Peter Finn	Austris Rungis
Mike Lagomarsino	Bruce Conhain
Susanna Farber	

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GENERAL INFORMATION

This handbook has been prepared to give you a summary of the following benefit programs under the Teamsters Local Union No. 856 Health & Welfare Fund.

Hospital and Medical Benefits
Prescription Drug Benefits
Vision Benefits
Life Insurance and Accidental Death & Dismemberment Benefits (For Actives ONLY)
Teamsters Assistance Program

Except for specified instances of self-payment of contributions to continue benefits, these programs are financed by employer contributions pursuant to Collective Bargaining Agreements between various Employers (Participating Employers), and Teamsters Local Union No. 856 Freight Checkers, Clerical Employees and Helpers.

The plans of benefits and eligibility for these benefits are subject to the terms of the Trust Agreement and to the Rules and Regulations adopted from time to time by the Board of Trustees. The Board has the sole discretion to interpret such rules and to make decisions in respect to benefits.

The tables on the following pages provide a brief summary of the benefits available under the Health and Welfare Fund‘s various plans.

TEAMSTERS LOCAL UNION NO. 856 HEALTH & WELFARE FUND
SCHEDULE OF BENEFITS
NON-MAINTENANCE OF BENEFITS (Non-MOB) CONTRACTS (Includes "Capped" MOB Contracts)

	TEAMSTERS DIRECT PAY PLAN							
	PLAN AA - Modified		PLAN A- Modified		PLAN E or Select Plan			
MEDICAL	**ANTHEM BLUE CROSS PPO IN-NETWORK**	**OUT-OF-NETWORK**	**ANTHEM BLUE CROSS PPO IN-NETWORK**	**OUT-OF-NETWORK**	**ANTHEM BLUE CROSS PPO IN-NETWORK**	**OUT-OF-NETWORK**	**KAISER HMO**	**ANTHEM BLUE CROSS EPO**
Annual Deductible:								
Per Individual	$250	$250	$250	$250	$250	$250	None	None
Family Maximum	$500	$500	$500	$500	$500	$500	None	None
Hospital:								
Daily Room and Board	Semi-private	Semi-private	Semi-private	Semi-private	Semi-private	Semi-private	No charge	No charge
Other Hospital Charges	90%	50% UCR	85%	50% UCR	80%	50% UCR	No charge	No charge
Ambulance per Trip	90%	90% UCR	85%	85% UCR	80%	80% UCR	No charge within area when authorized by Plan physician	No charge
Emergency Room	90%	90% UCR	85%	85% UCR	80%	80% UCR	$35 copay; waived if admitted	$50 copay; waived if admitted
Physician's Services:								
Office Visits	90%	75% UCR	85%	70% UCR	$20 copayment; no annual deductible	60% UCR	$15 (outpatient)	$15 (outpatient)
Outpatient/Inpatient Services	90%	75% UCR	85%	70% UCR	80%	60% UCR	$15 (outpatient)	$15 (outpatient)
Surgical	90%	75% UCR	85%	70% UCR	80%	60% UCR	No charge	No charge
Lab/X-Ray	90%	75% UCR	85%	70% UCR	80%	60% UCR	No charge	No charge
Other Services:								
Home Health Care	90%	75% UCR	85%	70% UCR	80%	60% UCR	No charge	No charge
Hospice	90%	75% UCR	85%	70% UCR	80%	60% UCR	No charge	No charge
Special:								
Preventive Care	100%, no deductible	Limited benefits; see page 65	100%, no deductible	Limited benefits; see page 65	100%, no deductible	Limited benefits; see page 65	No charge	No charge
Well Child Care	100%, no deductible	Limited benefits; see page 66	100%, no deductible	Limited benefits; see page 66	100%, no deductible	Limited benefits; see page 66	No charge	No charge
Out-of-Pocket Maximum: (per calendar year)	Coinsurance max of$1,000 per family; excludes deductible and copays	None	Coinsurance max of $1,500 per family; excludes deductible and copays	None	Coinsurance max of $2,000 per family; excludes deductible and copays	None	$1,500 per person; $3,000 per family	$2,000 Single; $3,000 Family
PRESCRIPTION DRUGS Copay per Rx	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand

Notes:

- Direct Pay Plans determined by Collective Bargaining Agreement; Enrollment choices are for carrier, which are Teamsters Direct Pay, Kaiser and Anthem Blue Cross EPO.
- UCR is the Plan's Usual, Customary and Reasonable fee.
- Prescription drug copays dependent on Collective Bargaining Agreement.

TEAMSTERS LOCAL UNION NO. 856 HEALTH & WELFARE FUND
SCHEDULE OF BENEFITS
MAINTENANCE OF BENEFITS (MOB) CONTRACTS (Does Not Include "Capped" MOB Contracts)

	TEAMSTERS DIRECT PAY PLAN					
	PLAN AA		PLAN A			
MEDICAL	**ANTHEM BLUE CROSS PPO IN-NETWORK**	**OUT-OF-NETWORK**	**ANTHEM BLUE CROSS PPO IN-NETWORK**	**OUT-OF-NETWORK**	**KAISER HMO**	**ANTHEM BLUE CROSS EPO**
Annual Deductible*:						
Per Individual	$150	$150	$150	$150	None	None
Family Maximum	$300	$300	$300	$300	None	None
Hospital:						
Daily Room and Board	Semi-private	Semi-private	Semi-private	Semi-private	No charge	No charge
Other Hospital Charges	100%	85% UCR	100%	80% UCR	No charge	No charge
Ambulance per Trip	85%	85% UCR	80%	80% UCR	No charge within area when authorized by Plan physician	No charge
Emergency Room	100%	100% UCR	100%	100% UCR	$35 copay; waived if admitted	$50 copay; waived if admitted
Physician's Services:						
Outpatient/Inpatient Services	100%	85% UCR	95%	80% UCR	No charge	$5 (outpatient)
Surgical	100%	85% UCR	95%	80% UCR	No charge	No charge
Lab/X-Ray	100%	85% UCR	95%	80% UCR	No charge	No charge
Other Services:						
Home Health Care	100%	85% UCR	95%	80% UCR	No charge	No charge
Hospice	100%	85% UCR	95%	80% UCR	No charge	No charge
Special:						
Preventive Care	100%, no deductible	85% up to $125/year	100%, no deductible	Limited benefits; see page 65	No charge	No charge
Well Child Care	100%, no deductible	85% up to $125/year	100%, no deductible	Limited benefits; see page 66	No charge	No charge
Out-of-Pocket Maximum: (per calendar year)	Coinsurance max of $500 per family; excludes deductible and copays	None	Coinsurance max of $500 per family; excludes deductible and copays	None	$1,500 per person; $3,000 per family	$2,000 Single; $3,000 Family
PRESCRIPTION DRUGS Copay per Rx	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand	$10 generic $20 brand

*May or may not have annual deductible, depending upon Collective Bargaining Agreement Maintenance of Benefits clause.

Notes:

- Direct Pay Plans determined by Collective Bargaining Agreement; Enrollment choices are for carrier, which are Teamsters Direct Pay, Kaiser and Anthem Blue Cross EPO.
- UCR is the Plan's Usual, Customary and Reasonable fee.
- Prescription drug copays dependent on Collective Bargaining Agreement.

TEAMSTERS LOCAL UNION NO. 856 HEALTH & WELFARE FUND
NON-MEDICARE RETIREE SCHEDULE OF BENEFITS

	TEAMSTERS DIRECT PAY PLAN			
	ANTHEM BLUE CROSS PPO IN-NETWORK	**OUT-OF-NETWORK**	**KAISER HMO**	**ANTHEM BLUE CROSS EPO**
MEDICAL BENEFITS				
Annual Deductible	$250 ($500 per family)	$250 ($500 per family)	None	None
Hospital				
Daily Room and Board	Semi-private	Semi-private	Semi-private	Semi-private
Hospital Charges	80%	50% UCR	No charge	No charge
Physician Services				
Office Visits	$20 copayment; no annual deductible	60% UCR	$15 per visit	$15 per visit
Outpatient/ Inpatient Services	80%	60% UCR	$15 per visit	$15 (outpatient)
Surgical	80%	60% UCR	No charge	No charge
Lab/X-Ray	80%	60% UCR	No charge	No charge
Other Services				
Home Health Care	80%	60% UCR	No charge	No Charge
Hospice	80%	60% UCR	No charge	No Charge
Emergency Services				
Emergency Room	80%	80% UCR	$35 copay, waived if admitted	$50 copay, waived if admitted
Ambulance per Trip	80%	80% UCR	No charge within area if authorized by Plan physician	No charge
Other				
Out-of-Pocket Maximum (per calendar year)	Coinsurance maximum of $2,000 per family (excludes deductible and copays)	None	$1,500 per person; $3,000 per family	$2,000 Single; $3,000 Family
Maximum Annual Benefit	Unlimited	Unlimited	Unlimited at Kaiser facilities	Unlimited
PRESCRIPTION DRUGS				
Copay per Rx	$10 generic, $20 brand	$10 generic, $20 brand	$10 generic, $20 brand	$10 generic, $20 brand

Notes:

- The Teamsters Direct Pay Plan will pay based on contracted fees at PPO providers or the plan's UCR (Usual, Customary and Reasonable) fee for non-PPO providers.

TEAMSTERS LOCAL UNION NO. 856 HEALTH & WELFARE FUND
MEDICARE RETIREE SCHEDULE OF BENEFITS

	TEAMSTERS DIRECT PAY PLAN (after coordinating with Medicare)	KAISER PERMANENTE SENIOR ADVANTAGE	UNITEDHEALTHCARE SECURE HORIZONS
MEDICAL BENEFITS			
Annual Deductible	$250 ($500 per family)	None	None
Hospital			
Daily Room and Board	Semi-private	Semi-private	Semi-private
Hospital Charges	80%	No charge	$250 per admission
Physician Services			
Office Visits	80%	$15 per visit	$15 per visit
Outpatient/ Inpatient Services	80%	$15 per visit	$15 per visit (outpatient)
Surgical	80%	No charge	$125 copayment
Lab/X-Ray	80%	No charge	No charge
Other Services			
Home Health Care	80%	No Charge	No Charge
Hospice	80%	No Charge	No Charge
Emergency Services			
Emergency Room	80%	$20 copay, waived if admitted	$50 copay, waived if admitted
Ambulance per Trip	80%	No charge within area if authorized by Plan physician	$50 if approved by PMG or IPA
Other			
Out-of-Pocket Maximum (per calendar year)	Coinsurance maximum of $2,000 per family (excludes deductible and copays)	$1,500 per person; $3,000 per family	$6,700 per person
Maximum Annual Benefit	Unlimited	Unlimited at Kaiser facilities	Unlimited
PRESCRIPTION DRUGS			
Copay per Rx	$10 generic, $20 brand	$10 generic, $20 brand	$10 generic, $20 brand

Notes:

- The Teamsters Direct Pay Plan will pay based on contracted fees at the plan's UCR (Usual, Customary and Reasonable) fee.

PLAN D

Plan D consists of an HMO Medical Benefit Only. The current HMO is Kaiser. There are no other benefits unless otherwise negotiated through a Collective Bargaining Agreement (CBA). Contact the Fund Office or your Union Local to find out what, if any, other benefits might be included in the CBA negotiated by your employer.

Benefits under the Kaiser HMO are not controlled by this document and are instead controlled by a totally separate and distinct document. Contact the Fund Office at (800) 297-4595 to receive a copy of the Evidence of Coverage which will show the benefits and level of coverage for the HMO.

DIRECT PAY EPO PLAN

Benefits under the EPO Plan are not controlled by this document and are instead controlled by a totally separate and distinct document. Contact the Fund Office at (800) 297-4595 to receive a copy of the Summary Plan Description which will show the benefits and level of coverage for the EPO Plan.

RULES AND REGULATIONS
Teamsters Local Union No. 856 Health and Welfare Fund

ADOPTION RESOLUTION

RESOLVED, that effective December 1, 1980, the Trustees of the Teamsters Local Union No. 856 Health and Welfare Fund hereby established the Health and Welfare Program set forth in the attached ‘‘Rules and Regulations Providing Welfare Benefits’’ upon the following understanding and conditions.

1. It is recognized that the benefits provided by the Rules and Regulations can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing employer has any liability, directly or indirectly to provide the benefits established hereunder beyond the obligation of the contributing employer to make contributions as stipulated in his collective bargaining agreement. In the event that at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in these Rules and Regulations shall be construed as obligating any contributing employer to make benefit payments or contributions (other than the contributions for which the contributing employer may be obligated by his collective bargaining agreement) in order to provide for the benefits established hereunder. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any employer, the union, signatory association or any other persons or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

2. None of the payments provided for in the Rules and Regulations are insured by any contract of insurance and there is no liability on the Board of Trustees or any other individual or entity to provide payment over and beyond the amount in the Fund collected and available for such purpose.

ARTICLE I
Definitions

Section 1. The term ‘‘individual employer’’ or ‘‘employer’’ means any employer which is a party to a collective bargaining agreement under which payments are made or to be made to the Fund, or any entity which has executed a Subscriber Agreement in a form approved by the Board of Trustees. The term shall also include Teamsters Local Union No. 856 and any labor council or other labor organization with which it is affiliated which make contributions to the Trust pursuant to a Subscriber Agreement; provided the inclusion of such organization is not a violation of any existing law or regulation; and provided such organization shall be an individual employer solely for the purposes of making contributions with respect to the work of its respective employees and shall have no other rights or privileges under the Trust as an individual employer.

Section 2. The term ‘‘Union’’ means Teamsters Local Union No. 856, affiliated with the International Brotherhood of Teamsters.

Section 3. The term ‘‘collective bargaining agreement’’ means the contract between Teamsters Local Union No. 856 and an individual employer, together with any amendment, extension or renewal of such contract, under which the employer is required to make payments to the Fund in order to provide health and welfare benefits for employees.

Section 4. The term ‘‘employee’’ means:

(1) a person employed under the terms of a collective bargaining agreement between the Union and an employer;

(2) a Trustee;

(3) a retiree, provided the retiree was a covered employee under the Trust in the month immediately prior to the date of his retirement and provided he meets the eligibility rules and regulations adopted by the Board of Trustees from time to time;

(4) corporate officers, management personnel, partners, individual proprietors, and employees not covered by any collective bargaining agreement with the Union but who are corporate officers, management personnel, partners, individual proprietors, or employees of an Employer party to a collective bargaining agreement with the Union and for whom appropriate contributions are made pursuant to rules and regulations adopted by the Board of Trustees from time to time;

(5) public employees for whom appropriate contributions are made pursuant to rules and regulations adopted by the Board of Trustees from time to time;

(6) an employee who loses eligibility under the Plan but who elects to make COBRA contributions for himself and/or his dependents or dependents;

(7) an individual previously eligible as an employee working under a collective bargaining agreement who becomes a self-employed member of the Union who makes appropriate contributions pursuant to rules and regulations adopted by the Board of Trustees from time to time.

Section 5. The term ‘‘dependent’’ means any of the following persons not otherwise ‘‘Employees.’’

(1) The ‘‘Employee’s’’ spouse or dependent domestic partner (see (4) below).

(2) The ‘‘Employee’s’’ child who is under the age of 26. A “child” also includes in accord with Internal Revenue Section 152(f) a natural child, a step child, an adopted child, an eligible foster child and a child for whom the employee is the Guardian of the person. For grandchildren, cousins, nieces/nephews and/or other relatives to be considered an Employee’s dependent child such a relative must reside with the employee and be listed as a dependent on the Employee’s tax return.

(3) On and after August 10, 1993, individuals required to be treated as dependents under ERISA Section 609 will be treated as dependents by the Plan. Such individuals include alternate recipients under a Qualified Medical Child Support Order and any child who has not attained the age of 18 who is placed with a participant for the purpose of adoption. A Medical Child Support Order is any judgment decree or order which provides for child support with respect to a child of a participant which is issued by a court of competent jurisdiction and which provides for child support with respect to a child of a participant under the plan for health benefit coverage to such a child and is made pursuant to a state domestic relations law and related to benefits under the Plan or enforces a law relating to medical child support described in Section 1908 of the Social Security Act. A proposed Medical Child Support Order must be provided in advance to the Fund Office in order that the Trustees may determine whether or not the order is a Qualified Medical Child Support Order. An order will be deemed qualified if it includes all information required under ERISA Section 609 and meets all requirements of ERISA Section 609. Additional information related to this subdivision is available from the Fund Office and will be supplied upon request.

(4) Certain collective bargaining agreements requiring contributions to the Fund include provisions calling for the "domestic partner" of an eligible employee working under the collective bargaining agreements to be treated as an eligible dependent of the eligible employee. This benefit is extended only to participants who work under a collective bargaining agreement calling for this benefit and only to the extent permitted by this plan provision. This benefit shall not be subsidized by those employers whose collective bargaining agreements do not call for the domestic partner of an eligible employee to be treated as an eligible dependent of the eligible employee. To prevent any prohibited subsidization, this benefit will be provided only in Plan Years where the employer contribution under a collective bargaining agreement calling for this benefit matches contributions being paid under other applicable collective bargaining agreements plus any additional amounts set by the Trustees for domestic partner coverage. In setting any additional amount required for domestic partner coverage, the Trustees rely upon the advice of the Fund's Consultant.

To the extent permitted above, an individual will be treated as a "dependent domestic partner" of an eligible employee only if all of the following conditions are met:

(a) The employee and domestic partner must be eighteen (18) years of age or older.

(b) The employee and domestic partner must share a close personal relationship and be responsible for each other's common welfare.

(c) The employee and domestic partner must be each other's sole domestic partner.

(d) Neither the employee nor the domestic partner may have been married to anyone nor had another domestic partner within the prior six (6) calendar months.

(e) The employee and domestic partner may not be related by blood to an extent that would bar their marriage in the State of California.

(f) The employee and domestic partner must share the same regular permanent residence with the intent to continue to do so indefinitely.

(g) The employee and domestic partner must agree to be responsible for each other's basic living expenses which are the cost of basic food, shelter and any other expenses of a domestic partner.

(h) The employee and domestic partner must be mentally competent to consent to a contract of domestic partnership when the domestic partnership commenced.

(i) The employee and domestic partner must have submitted a signed and notarized Affidavit of Domestic Partnership to the Fund Office.

(j) The employee and domestic partner must have submitted a copy of the Declaration of Domestic Partnership or Confidential Declaration of Domestic Partnership filed with the California Secretary of State or comparable document filed with a city or county officer pursuant to a city or local ordinance.

An eligible employee must submit completed "domestic partner" enrollment forms and a notarized Affidavit of Domestic Partnership to commence the enrollment process. The enrollment forms are available from the Fund Office.

When an eligible participant submits required materials to enroll a domestic partner, the Fund Office shall notify the participant's employer of the enrollment prior to initial eligibility for benefits. The employer must agree to include in the employee's W-2 statement as taxable income to the employee, the fair market value of coverage afforded the domestic partner as a dependent of the participant as approved by the Board of Trustees. The employer must also agree to pay any and all payroll taxes related to the taxable income shown on the participant's W-2 statement. Should the employer believe that extension of this benefit to a particular domestic partner does not constitute taxable income to the participant due to a proper interpretation of Internal Revenue Code Section 152 and all related Sections and on that basis not agree to report income and pay taxes as set forth in the preceding two sentences, the employer must agree to accept full and sole responsibility for that determination.

The "domestic partner" of an eligible employee shall be eligible for benefits on the first day of the month following the month in which the Fund Office has received: (1) the notarized Affidavit of Domestic Partnership; (2) the fully completed domestic partner enrollment forms; and, (3) the employer's agreement as to tax reporting and payment.

The Trustees reserve the right to require additional proof of ongoing eligible dependent domestic partner status at any time.

An eligible dependent domestic partner's eligibility will terminate on the earlier of the following dates: (1) when the collective bargaining agreement under which the employee works no longer provides for domestic partner coverage or no longer includes a sufficient contribution for domestic partner coverage; or (2) when the employee ceases to be eligible; or (3) the date the dependent domestic partner no longer qualifies as an eligible dependent domestic partner; or (4) the date the dependent domestic partner enters into full-time military, naval or air service.

(5) Spouse means a person to whom an employee is legally married.

Section 6. The term ''benefits'' or ''health and welfare benefits'' means benefit payments as may be provided under any plans developed and established by the Trustees pursuant to the Trust Agreement.

Section 7. The term ''Trust Agreement'' means the Trust Agreement establishing the Teamsters Local Union No. 856 Health and Welfare Fund, and any modification, amendment, extension or renewal thereof.

Section 8. The term ''Fund'' means the Teamsters Local Union No. 856 Health and Welfare Fund; the term ''Fund'' also means the Board of Trustees established by the Trust Agreement where applicable.

Section 9. The terms ''Board of Trustees,'' ''Board'' and ''Trustees'' mean the Board of Trustees established by the Trust Agreement.

Section 10. The term ''Plan'' means those Rules and Regulations as adopted and thereafter amended by the Board of Trustees.

Section 11. The term ''ERISA'' means the Employee Retirement Income Security Act of 1974 and any valid regulation issued pursuant thereto.

Section 12. The term ‘‘Hospital’’ means only an institution constituted, licensed and operated pursuant to law if engaged in providing, on an in-patient basis at the patient’s expense, diagnostic and therapeutic facilities for surgical and medical diagnosis, treatment and care of injured and sick individuals by or under the supervision of a licensed physician and surgeon and continuously provides 24-hour a day services by registered nurses. ‘Hospital’ also includes licensed Mental Health and/or Substance Use Disorder facilities. The term ’Hospital’ shall not include an institution or part thereof, which is other than incidentally a place for rest, a place for the aged, or a nursing home or convalescent hospital.

Section 13. ‘‘Convalescent Hospital’’ means a duly licensed institution meeting the conditions of participation for an extended care facility under Medicare, Title XVIII, of the Social Security Act, as enacted and amended.

Section 14. ‘‘Hospice’’ means a facility that provides a Hospice Care Program and operates in accordance with the laws of the jurisdiction where it is located. It operates as a unit or program that only admits terminally ill patients. It is separate from any other facility but may be affiliated with a hospital, nursing home or home health care agency.

Section 15. ‘‘Resident Patient’’ means a ‘‘Participant’’ who is confined in a hospital and for whom a room and board charge is made.

Section 16. ‘‘Physician’’ means a doctor operating within the scope of his license as: (a) Medical Doctor, M.D.; (b) Osteopath, D.O.; (c) Podiatrist, D.P.M.; (d) Doctor of Dental Surgery, D.D.S.; (e) Chiropractor, D.C.; (f) Optometrist, O.D.; (g) Licensed Clinical Social Worker; (h) Psychologist, Ph.D.; (i) Licensed Acupuncturist (must be M.D., D.O., D.C. or L.Ac.); (j) Licensed Marriage and Family Therapist; (k) Licensed Educational Psychologist; (l) Licensed Professional Clinical Counselor; (m) Certified Nurse Midwife; (n) Physician Assistant (P.A.); (o) Certified Registered Nurse Anesthetist (C.R.N.A); (p) Registered Dietitian (R.D.); (q) Certified Nutritionist; (r) Physical Therapist; (s) Occupational Therapist; (t) Speech and Language Pathologist.

Section 17. ‘‘Medically Necessary’’ means that each service or supply meets all of the tests listed below:

(a) It is rendered for the treatment or diagnosis of an injury or disease, including premature birth, congenital defects, and birth defects;

(b) It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards;

(c) It is not mainly for the convenience of the Participant or of the Participant’s physician or other provider; and

(d) It is the most appropriate supply or level of service needed to provide safe and adequate care. When applied to confinement in a Hospital or other facility, this test means that the Participant needs to be confined as an inpatient due to the nature of the services rendered or due to the Participant’s condition and that the Participant cannot receive safe and adequate care through outpatient treatment.

Section 17.1. Effective January 1, 2021 in terms of preauthorization, retrospective authorization and claims payments as to the medical necessity for the diagnosis, prevention and treatment of mental health and substance use disorders the Plan shall apply the standards adopted by the State of California in Senate Bill No. 855 as well as any amendments to those statutory provisions subsequently adopted by the State of California and any regulatory provisions adopted by the State of California in terms of such provisions. This Section in no fashion alters any provision of the Plan related to the requirements that a Participant obtain preauthorization for various care nor any provisions of the Plan related to the Preferred Provider Network of the Plan It is the understanding of the Board of Trustees that this Section provides greater protection to Participants than that afforded under the federal Mental Health Parity Act. Other than the standard of medical necessity, this Plan Section neither adds nor reduces any benefit available under the Plan.

Section 18. ‘‘Reasonable Charges or Expenses’’ means the usual, customary, and reasonable charges for the area wherein such expenses are incurred, as determined by the Fund.

Section 19. ‘‘Eligible’’ or ‘‘Eligible Participant’’ means an ‘‘employee’’ as defined in Section 4, or a “dependent” as defined in Section 5, who is eligible to receive benefits under this Plan.

ARTICLE II
Eligibility

Section 1. ***Collective Bargaining Employees and Dependents.***

A. Eligible Status

Each person is in an eligible status if he is in employment as an employee of an Employer and who is covered by the terms of a collective bargaining agreement between the Employer and the Union.

An employee who performs services for more than one Employer shall not be entitled to benefits greater than those which would apply if his services were performed for but one of such employers.

B. Eligibility Date for Benefits

The Eligibility Date for each employee who enters an eligible status shall be determined as follows:

(1) If a person is in an eligible status on the effective date of the Plan, his Eligibility Date is the effective date of the Plan.

(2) If a person enters an eligible status after the effective date of the Plan, his Eligibility Date is the first day of the month following a period of 90 days of continuous employment provided he works at least 80 hours in each complete calendar month during such period and the contributions required by the collective bargaining agreement are payable on his behalf. If such person is eligible for health benefits, selection of coverage shall be the Direct Pay Plan or the Kaiser Permanente Health Plan depending on the type of collective bargaining agreement. If eligible for dental coverage, benefits will be provided through the DeltaCare USA Dental Plan or UHC Dental DHMO Plan. If eligible for benefits at the next open enrollment period, such person, in addition to the foregoing, may select coverage under the appropriate Direct Pay Dental Plan. If you are an employee covered under a Collective Bargaining Agreement with Maintenance of Benefits language, you have a choice of the DeltaCare USA Dental Plan, UHC Dental DHMO Plan and the Direct Pay Dental Plan commencing with the first month of eligibility.

(a) A “new hire” is a person who has not been eligible for benefits under the Plan in any of the 12 consecutive months prior to their Eligibility Date and who does not work for a Maintenance of Benefits Employer. A new hire’s Eligibility Date is the first day of the month following a period of 90 days of continuous employment provided they work at least 80 hours in each calendar month during such period and the contributions required under the collective bargaining agreement are payable on their behalf. If the new hire is eligible for health benefits, selection of coverage shall be the Direct Pay Plan or the Kaiser Permanente Health Plan, depending on the type of collective bargaining agreement. If the new hire is eligible for dental benefits they must enroll in the DeltaCare USA Dental DHMO Plan or UHC Dental DHMO Plan. New hires are not eligible to participate in the Direct Pay Dental Plan until the first regular open enrollment following at least 12 consecutive months of eligibility. If eligible for benefits at the next open enrollment period, such person may select coverage under the appropriate Direct Pay Dental Plan. A new hire must submit enrollment forms in order to receive benefits. Should a new hire not timely submit enrollment forms the effective date of their coverage will be the effective date determined by the HMO program in which they enroll for health coverage and the effective date determined by DeltaCare USA or UHC Dental for dental coverage. The current HMO provider is Kaiser Permanente Health Plan. The current prepaid dental programs are DeltaCare USA Dental DHMO Plan or UHC Dental DHMO Plan.

(b) A "Maintenance of Benefits Employer" is an Employer whose collective bargaining agreement provides the Employer shall contribute the whole cost of benefits under the Plan throughout the term of the Employer's collective bargaining agreement. The Fund shall upon request supply you with a list of current Maintenance of Benefits Employers.

If a person working for a Maintenance of Benefits Employer enters an eligible status after the effective date of the Plan their Eligibility Date is the first day of the month following a period of 90 days of continuous employment provided they worked at least 80 hours in each complete calendar month during such period and the contributions required by the collective bargaining agreement are payable on their behalf. If such person is eligible for benefits they may enroll in any of the appropriate health and dental plans available to them. Should such an individual fail to submit enrollment forms they shall be enrolled in the appropriate Direct Pay Plans but no benefits shall be payable until enrollment materials are received by the Fund. Should an individual who has not timely submitted enrollment forms subsequently submit enrollment forms for an available HMO or prepaid dental plan the effective date of their coverage under such plan will be the effective date determined by the HMO provider for medical coverage or prepaid dental plan for dental coverage. Current HMO provider is Kaiser Permanente Health Plan. The current prepaid dental plans are the DeltaCare USA Dental DHMO Plan and UHC Dental DHMO Plan.

EXCEPTIONS:

A new hire who does not reside in the DeltaCare USA Dental DHMO Plan or UHC Dental DHMO Plan service area may enroll in the appropriate Direct Pay Dental Plan for dental coverage.

Some collective bargaining agreements provide that only certain benefits are available to employees, for example, Plan D contracts provide only HMO medical coverage. The enrollment rights and benefits payable to such employees are limited to those provided for in the collective bargaining agreement with their employer. Copies of applicable collective bargaining agreements are available from Teamsters Local Union No. 856.

(3) The effective date of a new Employer contract may be considered the effective date of the Plan to establish eligibility, as in Paragraph (1) above.

(4) If a person returns to an eligible status (by way of active employment) within 12 months after his benefits under the Plan have terminated, his Eligibility Date shall be the first day of the month next following the month in which he worked at least 80 hours for his employer. This rule does not apply to loss of eligibility due to disability.

Due to the COVID-19 situation, the months of March, 2020 through May 2023 (the "Covid Window") may be excluded for determining whether or not a person who was last eligible for coverage in February of 2020 may return to eligible status. Any loss of coverage in the Covid Window shall not be included for tolling purposes to determine whether a participant has been without coverage for more than 12 months for re-qualification purposes.

(5) Each person who is represented by Teamsters Local Union No. 856 who enters an eligible status by transfer from another local union affiliated with the International Brotherhood of Teamsters will become eligible on the first day of the month next following a calendar month in which the person worked at least 80 hours for his employer. Each person who is represented by Teamsters Local Union No. 856 who enters an eligible status by transfer from prior employment with the same employer outside of the Teamsters Local Union No. 856 bargaining unit will become eligible on the first day of the month next following a calendar month in which the person works at least 80 hours for the same employer within the Teamsters Local Union No. 856 bargaining unit so long as the employee received health and welfare coverage during that period of employment with the same employer.

(6) Due to the COVID-19 situation, the months of March, 2020 through and including May 2023 may be disregarded in determining whether or not an employee has been eligible due to active employment for 12 out of the 15 preceding months. Two forms of disability extensions are available to employees who have been eligible due to active employment for 12 out of the 15 preceding months prior to incurring a disability. They are:

(a) Three months' waiver of contribution payments upon cessation of active work because of disability. This extension will include Plan coverage for the employee and all eligible dependents. A completed application for this extension must be signed by your physician and submitted to the Fund Office.

(b) ***Direct Pay Plan Only***: Employees who are totally disabled upon date of termination of coverage, are eligible for up to twelve months of medical coverage for themselves only, and only for the disabling condition. The total disability must not be work related (unless coverage is required by law) and must be continuous from the date coverage ends to the treatment or service date(s). Covered charges must be the result of the injury or sickness causing the disability that exists on the date coverage ended. A signed Extension of Benefits/ Medical Coverage option form, which includes a rejection of COBRA coverage, must be submitted when choosing (b). For a complete description of this disability extension see page 69.

By electing (a) above, COBRA coverage rights are not forfeited. However, the three months of waiver will be counted when figuring the maximum number of months mandated by COBRA. For example: COBRA continuation period is 18 months for termination of employment and if the three months' waiver of contributions is taken there remains 15 months of COBRA extension. Further, Kaiser members may wish to consider other options of continuous membership plans for which they qualify. Such plans may be maintained without a time limit. Information relative to these options may be obtained by contacting Kaiser directly.

(7) Certain collective bargaining agreements provide that collective bargaining employees may decline coverage under this Plan if the employee proves to the employer coverage from some other Plan. The employer is the sole authority to determine if an employee is eligible to decline coverage. An employee declining coverage shall receive no benefits from this Plan and accrue no eligibility for retiree coverage during periods of employer approved declination of coverage. An employee declining coverage may enroll for benefits under this Plan during the employer's annual open enrollment process. Eligibility under this Plan following any enrollment will be the first day of the month following enrollment if the employee meets the 80 hour work per month requirement. Employees declining coverage also have special enrollment rights under HIPAA. An employee who declines coverage and loses eligibility under his or her other plan may within 30 days of that loss of coverage enroll in this Plan. Proof of other coverage and the date of loss of coverage is required for this special enrollment. Eligibility under this Plan following such special enrollment is the first day of the month following enrollment if the employee meets the 80 hour work per month requirement. In the same fashion, if an otherwise eligible employee who has declined coverage under this Plan obtains a new spouse or dependent by marriage, birth, adoption, placement for adoption, placement for foster care or appointment as legal guardian, the individual previously declining coverage has 30 days in which to request special enrollment under this Plan. Proof of the date on which a new spouse or dependent was acquired is required for this special enrollment. Eligibility under this Plan following such special enrollment is the first day of the month following enrollment if the employee meets the 80 hour work per month requirement.

Certain Collective Bargaining Agreements providing for a declination of coverage as set forth above provide that the employer shall contribute to the Fund 35% of the normal contributions on employees opting out of coverage and that months of such a declination of coverage, employment and contributions count towards retiree eligibility. Notwithstanding the foregoing paragraph, such months under such a Collective Bargaining Agreement shall be counted for retiree eligibility purposes so long as the employee initially declining coverage enrolls for coverage as an active employee and maintains eligibility for at least 12 months prior to retirement.

Section 2. *Trustees*

To cover Trustees, a Subscriber Agreement must be signed by each Trustee desiring coverage. All new Trustees desiring to enroll must enroll within 60 days of their appointment. If a new Trustee fails to enroll within 60 days of his appointment then his enrollment rights are limited to those set forth in Subsection C (1) or (2). In order for a new Trustee failing to enroll to maintain the right to subsequently enroll pursuant to Subsection C (1) the new Trustee must advise the Trustees in writing within 60 days of the appointment that the new Trustee is not enrolling due to preexisting health coverage. If this written notice is not given by the Trustee within the required 60 days then the new Trustee shall have no right of late enrollment pursuant to Subsection C (1). Upon appointment the Fund shall provide written notice of this Section and its restrictions to each new Trustee.

A. In order to maintain eligibility, contributions must be paid by the Trustee by the date designated as the due date on the Subscriber Agreement and the monthly employer remittance form.

B. (1) If a Trustee declines enrollment because of other health coverage he may in the future be able to enroll provided that he requests enrollment within 30 days after the other coverage ends.

(2) In addition, if a Trustee who has declined enrollment obtains a new dependent as a result of marriage, birth, adoption, placement for adoption, placement for foster care or appointment as legal guardian, the Trustee may enroll provided he requests enrollment within 30 days after the date the new dependent was acquired.

Section 3. *Retirees*

A. If you retire from employment as an ‘‘employee’’ as defined under the Plan, with an employer who is making the required contributions for retiree coverage, you will be eligible for retiree benefits provided:

(1) You were in an eligible status under this Plan for a total of 120 months with an employer who was making contributions on your behalf for retiree coverage, and

(2) You were eligible for benefits under this Plan for at least 12 continuous months immediately prior to the date of your retirement with an employer who was making contributions on your behalf for retiree coverage under this Plan, and

(3) You have attained at least age 55 on the date of your retirement or were disabled on the date of your retirement or were entitled to receive periodic pension payments within two months of the date of your retirement, and

(4) You must apply for retiree coverage under the Plan no later than 6 months after your retirement date or within 6 months of receiving a Social Security Administration Disability Award and you meet the 120 months and one year requirements for retiree medical coverage as of the date of disability as determined by the Social Security Administration.

(5) The only exception to the 6 month initial enrollment deadline is the Special Enrollment required under HIPAA. To retain this initial Special Enrollment right you must advise the Fund in writing you are declining coverage under the Retiree Plan because you have coverage from another source. This signed statement must be received by the Fund prior to the expiration of the 6 month period. A spouse may decline initial enrollment through the same process. If a required statement is not received within the 6 months all HIPAA Special Enrollment rights are lost. If you have provided timely notice to the Fund you may subsequently enroll within 30 days of loss of your other coverage. If you do not enroll within 30 days of loss of your other coverage all HIPAA Special Enrollment rights are lost. You must submit written proof of your other coverage, its duration and the date of loss of coverage. If eligible for HIPAA Special Enrollment coverage will commence on the first day

of the month following the month the Fund receives you application for enrollment. The foregoing Special Enrollment rights only apply during initial enrollment. After initial enrollment if you and/or your spouse obtain other coverage due to employment you may so advise the Fund in writing requesting prospective disenrollment for the balance of the period of that other coverage. If you do not again enroll within 30 days of loss of that other coverage all rights to re-enroll in this Plan will be lost. At the time of re-enrollment you must submit proof of the other coverage, its duration and the date of loss of coverage. If eligible you and/or your spouse's coverage will commence on the first day of the month following the month the Fund receives your application for re-enrollment. The foregoing rights only apply for re-enrollment.

If this Plan replaced another benefit plan that included retiree benefits provided by your employer, your months of eligibility under the former plan will be counted to qualify for the 120 months required under subpart (1) providing you were insured as an active employee under the former plan for the month immediately preceding your eligibility date in this plan. Your eligibility under said former plan will not be counted to meet the 1 year requirement under subpart (2) above. Months of eligibility under any health and welfare plan established pursuant to a collective bargaining agreement between an employer and an affiliate of the International Brotherhood of Teamsters shall also be counted to qualify for the 120 months under subpart (1) above providing you were insured as an active employee under said plan for the month immediately preceding your eligibility date in this Plan and provided that the other plan included retiree benefits. Said eligibility shall not be counted under subpart (2) above.

If your employer has been providing you coverage under this Plan prior to commencing contributions on your behalf for retiree coverage then all your months of coverage due to employment with that employer will be counted to qualify for the 120 months under subpart (1) above. Months of coverage prior to the commencement of retiree contributions on your behalf shall not be counted under subpart (2) above.

If you are qualified to receive any retiree medical benefits under the other plan, you will not receive any retiree medical benefits from this Plan.

For retiree applications received from public sector employees on or before March 31, 2006, such a participant's prior coverage under a private or public sector health plan which included retiree medical coverage shall be credited to the participant for purposes of the 120 month requirement of this section but shall not be credited to the participant for purposes of the 12 month requirement of this section.

For retiree applications received from public sector employees on or after October 1, 2013, such as a participant's prior coverage under a public sector health plan which included retiree medical coverage shall be credited to the participant for purposes of the 120 month requirement of this Part but shall not be credited to the participant for purposes of the 12 month requirement of this Part.

Effective September 1, 2009 the lawful surviving spouse of an Active Plan Employee may enroll for retiree benefits if all of the following conditions are met: (1) at the time of death of the Employee the Employee was eligible for benefits due to employment, COBRA or a disability extension; (2) at the time of death of the Employee that Employee met all requirements for retiree benefits except for the enrollment requirement; and, (3) the surviving spouse, within 6 months of the date of death of the Employee applies for retiree coverage. Coverage shall be subject to the self-payment requirements for surviving spouses of retired Employees. The timely enrollment requirements for a surviving spouse are subject to the Special Enrollment required under HIPAA set forth in part (5) of this sub-section.

For applications received on and after August 1, 2013, if an Employee's coverage terminated due to a disability, and the Employee receives a Social Security Disability award related to that disability then in that event for all purposes of this Part a total of 100 months of coverage shall be sufficient to meet the 120 month requirement of this Part.

B. Your retired employee benefits will become effective on the later of: (1) the date you first qualify under Section 3, part A; (2) the first day of the month following the date you ceased to be eligible for benefits as a collective bargaining employee under Section (1) above; or, (3) the first day of the month following the month in which a timely application for retiree medical coverage is filed subsequent to a Social Security Administration Disability Award.

Your benefits will continue as long as the contributions continue to be paid by your former employer, unless your former employer ceases doing business, and required self-payments are timely paid by you to the Fund and the Plan remains in force. Should your former employer discontinue contributions and continue doing business, your benefits will continue as long as the required self-payments, including that portion of contribution formally paid by your former employer, are timely paid by you to the Fund and the Plan remains in force.

While you are alive, the benefits for your dependents will continue for as long as your benefits continue and your dependents qualify as dependents under the Plan and as long as the Plan remains in force. If you are eligible at the time of your death, the benefits of your surviving spouse will continue until either your spouse's death or your spouse's coverage under some other plan and as long as the Plan remains in force. If your spouse's benefits continue after your death, benefits for your other dependents at the time of your death will continue as long as your spouse's benefits continue and those dependents continue to qualify as dependents under the Plan and as long as the Plan remains in force. In no event shall benefits be provided to a subsequent spouse of your surviving spouse.

C. The following self-payments in effect as of July 1, 2017 shall be required on a monthly basis commencing with the first month during which you are otherwise eligible to receive benefits pursuant to item 3-B above:

REQUIRED MONTHLY SELF-PAYMENTS FOR COVERAGE UNDER THE RETIREE PLAN OF BENEFITS:

REQUIRED MONTHLY SELF-PAYMENTS		
	Direct Pay Plan (PPO or EPO)	HMO (Kaiser or UHC)
For each eligible person:		
Under Age 60 without Medicare	$708	$608
Age 60 or older without Medicare	$508	$404
Age 60 or older with Medicare	$221	$185

Surviving Spouses and Surviving Spouses with Dependents must call the Fund Office for the amount of their required monthly self-payment.

The required monthly self-payments to add an eligible child shall be $250 per month for 1 child or $500 per month for 2 or more children. If adding a child who has Medicare, the additional required monthly self-payment will be $115.

The foregoing rates are subject to change at any time at the discretion of the Trustees. The Administrator shall bill you monthly after your application for coverage has been approved. Failure to pay the amounts within twenty-five days of the date due may result in termination of your coverage.

RETIREE PLUS COVERAGE

On April 29, 2019 the Trustees provided to the bargaining parties a rate to provide retiree coverage with no required monthly self-payment. Under this rate, the employer pays an additional amount per active employee per month and an eligible retired employee and their eligible enrolled dependents receive retiree coverage with no required self-payment. It is solely an issue for the bargaining parties to adopt or not adopt this retiree plus contribution rate. In addition to meeting the basic eligibility requirements of Subpart A above, you must have accrued 240 months of coverage calculated under Subpart A and you must have been eligible for at least 12 continuous months immediately prior to the date of your retirement with an employer who throughout that 12 month period paid the required additional contribution for retiree plus coverage for all eligible employees. For retirees and eligible dependents enrolled in retiree plus coverage, the Trustees reserve the right to prospectively impose required monthly self-payment amounts at any time at the discretion of the Trustees.

D. Enrollment of the Dependents of Retirees: If you wish dependent coverage, subject to the exceptions set forth below, you must at the time of your enrollment in the Retiree Plan enroll your eligible dependents and their coverage subsequent to enrollment must be continuous through the date they no longer qualify as your dependent.

(1) Other Coverage: If you decline enrollment for a dependent upon your initial enrollment because that dependent has other health coverage you may subsequently enroll that individual as an eligible dependent only if both of the following conditions are met. First, at the time of your enrollment you must notify the Fund in writing of the name of the dependent and the name of the Health Plan they are covered by. Second, within thirty days of that dependent losing that other coverage you must enroll that dependent in this Plan. At the time of this special enrollment the individual must meet the definition of a dependent under these Rules and Regulations. At the time of this special enrollment you must provide evidence of this individual's prior health coverage and the date of loss of coverage.

(2) Subsequent Dependents: If subsequent to your initial enrollment you have a new dependent as a result of marriage, birth, adoption, placement for adoption, placement of a foster child, or legal guardianship you may enroll your new dependent. However you must apply for enrollment within 30 days after the marriage, birth, adoption, placement for adoption, placement of a foster child, or your appointment as legal guardian. At the time of this special enrollment you must supply proof of the date of the event giving rise to this special enrollment right.

E. Effective January 1, 2003 Retirees who retired from employment with an employer that provides domestic partner coverage to its active employees may enroll their domestic partner as an eligible dependent under the Retiree Plan. Self-payment on behalf of a retiree with an enrolled domestic partner shall be the same as that required of a retiree with a spouse. In order to enroll a domestic partner the retiree must agree to accept full and sole responsibility for all taxes payable due to the coverage being afforded the domestic partner.

To the extent permitted above, an individual will be treated as a "dependent domestic partner" of an eligible retiree only if all of the following conditions are met:

(a) The domestic partner must be eighteen (18) years of age or older.

(b) The Retiree and domestic partner must share a close personal relationship and be responsible for each other's common welfare.

(c) The Retiree and domestic partner must be each other's sole domestic partner.

(d) Neither the Retiree nor the domestic partner may have been married to anyone nor had another domestic partner within the prior six (6) calendar months.

(e) The Retiree and domestic partner may not be related by blood to an extent that would bar their marriage in the State of California.

(f) The Retiree and domestic partner must share the same regular permanent residence with the intent to continue to do so indefinitely.

(g) The Retiree and domestic partner must agree to be responsible for each other's basic living expenses which are the cost of basic food, shelter and any other expenses of a domestic partner.

(h) The Retiree and domestic partner must be mentally competent to consent to a contract of domestic partnership when the domestic partnership commenced.

(i) The Retiree and domestic partner must have submitted a signed and notarized Affidavit of Domestic Partnership to the Fund Office.

(j) The Retiree and domestic partner must have submitted a copy of the Declaration of Domestic Partnership or Confidential Declaration of Domestic Partnership filed with the California Secretary of State or comparable document filed with a city or county officer pursuant to a city or local ordinance.

The Retiree must agree to include in the taxable income of the Retiree the fair market value of coverage afforded to the domestic partner as a dependent of the Retiree. The Retiree must agree to pay any and all taxes related to the taxable income attributable to coverage. Should the Retiree believe that extension of this benefit to a particular domestic partner does not constitute taxable income to the Retiree due to a proper interpretation of Internal Revenue Code §152 and all related Sections and on that basis not agree to report income and pay taxes as set forth in the preceding two sentences, the Retiree must agree to accept full and sole responsibility for that determination.

The domestic partner of an eligible Retiree shall be eligible for benefits on the first day of the month following the month in which the Fund Office has received: (1) the notarized Affidavit of Domestic Partnership; (2) the fully completed domestic partner enrollment forms; and, (3) the Retiree's agreement as to tax reporting and payment.

The Trustees reserve the right to require additional proof of ongoing eligible dependent domestic partner status at any time.

An eligible dependent domestic partner's eligibility will terminate on the earlier of the following dates:

(1) When the Retiree ceases to be eligible;

(2) The date the dependent domestic partner no longer qualifies as an eligible dependent domestic partner; or,

(3) The date the dependent domestic partner enters into full-time military, naval or air service.

F. SPECIAL RULE FOR MEDICARE "DOUBLE COVERAGE" MEMBERS

Commencing August 1, 2008 Medicare advised the HMOs that a Medicare eligible retiree and/or spouse could not be enrolled in two Health Plans. This most frequently occurs when a retiree and spouse both receive retiree coverage from different Health Plans due to prior employment and each

is enrolled in the other's Plan as a dependent. Medicare is applying this restriction even when all enrollment is in a single HMO. Retirees and/or spouses who are in such a, "double coverage" situation will be advised by their HMO or Medicare they must terminate coverage under one Health and Welfare Plan and elect coverage under the other Health and Welfare Plan. If the retiree and/or spouse fail to make the election the HMO will terminate their coverage under one Health and Welfare Plan. This special rule is adopted due to Medicare's actions. It provides an exception to the general eligibility rule that termination of participation in the Retiree Plan prohibits any later re-enrollment. All of the following seven conditions must be met in order for a right to re-enrollment to exist.

(1) The Medicare Retiree and/or spouse must have been enrolled in this Retiree Plan.

(2) The Medicare Retiree and/or spouse must have received a "Double Coverage Notice" from their HMO or Medicare.

(3) The Medicare Retiree and/or spouse must have, in response to the Notice, elected to terminate coverage under this Retiree Plan or had such coverage terminated by their HMO or Medicare.

(4) The Medicare Retiree and/or spouse must have continued coverage under the other Health Plan.

(5) The Medicare Retiree and/or spouse must have subsequently lost coverage under the other Health Plan.

(6) The Medicare Retiree and/or spouse within 30 days of loss of coverage under the other Health Plan re-enrolls in this Retiree Plan.

(7) The Medicare Retiree and/or spouse must submit within their re-enrollment application written proof of conditions (1) thru (6) set forth above.

G. ADDITIONAL BENEFITS FOR RETIRED PARTICIPANTS WHO RETIRED FROM UNITED PARCEL SERVICE

- United Parcel Service Retirees who retired on or after August 1, 2002 are required to make a monthly self-payment, as determined by the Board of Trustees, beginning on July 1, 2016. The amount of the required monthly self-payment for anyone who retired before July 1, 2016 shall be equal to the required monthly self-payment for Retirees with Medicare. For those who retire on or after July 1, 2016, while you are younger than age 60 without Medicare, you will be required to pay the same monthly self-payment rate as all other retirees under age 60 without Medicare. When you turn age 60, you will be required to pay the rate equal to the required monthly self-payment rate for Retirees with Medicare.

- VSP vision benefits will be an additional benefit plan for United Parcel Service retirees who retired on or after August 1, 2002.

- Dental Plan 2 coverage will be an additional plan for United Parcel Service Retirees who retired on or after August 1, 2002.

These changes do not affect any retirees that retired before August 1, 2002 or any retirees from the Tennessee location.

These additional benefits are being provided to a specific group of retirees in accord with additional contributions received under certain UPS collective bargaining agreements. As with all benefits under the Plan, these extraordinary benefits are subject to change at any time at the sole discretion of the Board of Trustees. If any change is adopted by the Board of Trustees, you will be notified in advance of the effective date of the change.

REQUIRED MONTHLY SELF-PAYMENTS FOR UPS RETIREES FOR COVERAGE UNDER THE RETIREE PLAN OF BENEFITS:

REQUIRED MONTHLY SELF-PAYMENTS		
	Direct Pay Plan (PPO or EPO)	HMO (Kaiser or UHC)
For each eligible person:		
Under Age 60 without Medicare	$708	$608
Age 60 or older without Medicare	$221	$185
Age 60 or older with Medicare	$221	$185

Surviving Spouses and Surviving Spouses with Dependents must call the Fund Office for the amount of their required monthly self-payment.

The required monthly self-payments to add an eligible child shall be $250 per month for 1 child or $500 per month for 2 or more children. If adding a child who has Medicare, the additional required monthly self-payment will be $115.

The foregoing rates are subject to change at any time at the discretion of the Trustees. The Administrator shall bill you monthly after your application for coverage has been approved. Failure to pay the amounts within twenty-five days of the date due may result in termination of your coverage.

Section 4. ***Self-Employed Members of Teamsters Local Union No. 856***

A. To continue coverage for collective bargaining unit employees who become self-employed members of Teamsters Local Union No. 856 a Subscriber Agreement must be signed. Each individual becoming a self-employed member of Teamsters Local Union No. 856 must enroll within 60 days of their self-employment. If a self-employed member of Teamsters Local Union No. 856 fails to enroll within 60 days of his self-employment then his enrollment rights are limited to those set forth in Subsection C (1) or (2). In order for a newly self-employed member of Teamsters Local Union No. 856 failing to enroll to maintain the right to subsequently enroll pursuant to Subsection C (1) the newly self-employed member of Teamsters Local Union No. 856 must advise the Trustees in writing within 60 days of self-employment that the newly self-employed member of Teamsters Local Union No. 856 is not enrolling due to preexisting health coverage. If this written notice is not given by the newly self-employed member of Teamsters Local Union No. 856 within the required 60 days then the newly self-employed member of Teamsters Local Union No. 856 shall have no right of late enrollment pursuant to Subsection C (1). Upon attainment of self-employment the Fund shall provide written notice of this Section and its restriction to each newly self-employed member of Teamsters Local Union No. 856.

B. In order to maintain eligibility, contributions must be paid each month by the due date designated as the due date on the Subscriber Agreement and the monthly remittance form.

C. (1) If a self-employed member of Teamsters Local Union No. 856 declines enrollment because of other health coverage he may in the future be able to enroll provided he requests enrollment within 30 days after the other coverage ends.

(2) In addition if a self-employed member of Teamsters Local Union No. 856 obtains a new dependent as a result of marriage, birth, adoption, placement of adoption, placement for foster care or appointment as legal guardian, the self-employed member of Teamsters Local Union No. 856 may enroll provided he requests enrollment within 30 days after the marriage, birth, adoption, placement for adoption, placement for foster care or appointment as legal guardian.

Section 5*. Employees of a Covered Employer Who Are Not Covered Under the Collective Bargaining Agreement Including Corporate Officers, Management Personnel and Individual Proprietors*

A. To provide coverage for persons in the above-mentioned classifications a Subscriber Agreement must be signed and all persons in those classifications actively working at the establishment must be listed.

All new persons in these classifications must be enrolled on the first monthly report to the Fund after their date of hire.

B. In order to maintain eligibility, contributions must be paid for all persons each month by the date designated as the due date and on the monthly employer remittance form.

C. If there is more than one employee not covered under the Collective Bargaining Agreement, all in each work classification must enroll, or none. Participation is open only to persons who are actively working.

D. The above-mentioned classifications of present contributing employers not presently covered by the Plan may be covered only if they provide evidence of insurability as required by the Fund.

E. The only individuals who are actively working who may be excluded from coverage are individuals covered by another collective bargaining agreement which requires contributions to another health and welfare program.

F. For purposes of this Section, the term ''actively working'' means working at least 80 hours per month. It is the responsibility of the contributor to assure that appropriate records are kept in order to reflect that individuals are in fact actively working 80 hours per month. Days of illness and vacation days will only be considered to be days on which the individual is ''actively working'' to the extent that collective bargaining unit employees are treated as ''actively working'' for purposes of contributions during periods of illness and vacation.

Section 6*. Public Employees*

The rules for eligibility to participate as established by the public entity and as acceptable to this Fund, subject to payment of appropriate payments.

Should the public employer permit employees to elect coverage under this and any other plan, an employee must at his first opportunity elect and continue to participate in this Plan if the employee wishes to participate in this Plan without providing evidence of insurability. The provisions of Article II, Section 1(B)(2) shall be applied in determining initial eligibility.

Section 7. *Dependents*

A. Eligible dependents include your spouse, your Domestic Partner to the extent permitted by Article I, Section 5, Part 4 and your children, excluding in any case:

(1) The Employee's child following the close of the month in which the child attains his or her twenty-sixth birthday. A child includes in accord with Internal Revenue Section 152(f) a natural child, a stepchild, an adopted child, an eligible foster child and a child for whom the Employee is the Guardian of the person. For grandchildren, cousins, nieces/nephews, and/or other relatives to be considered an Employee's dependent child such a relative must reside with the Employee and be listed as a dependent on the Employee's tax return.

(2) Your spouse, if legally separated from you.

(3) A child(ren) of your Domestic Partner.

If your unmarried dependent child is incapable of self-sustaining employment because of mental or physical handicap on the date his benefits would otherwise terminate on account of age and if within 31 days of that date you submit satisfactory proof of his incapacity, his medical expense benefits will be continued during the period of his incapacity. This extension will continue until the earliest of: (1) the date he ceases to be eligible for reasons other than age; (2) the date he ceases to be incapacitated; or, (3) the 31st day following request of additional proof of his incapacity if you fail to furnish such proof.

B. Effective Date of Dependent Benefits

In order to be eligible for dependent benefits, you, the employee, must be eligible for benefits, in which event the benefits for your eligible dependents will become effective on the latest of the following dates:

(1) On the date your benefits become effective.

(2) On the date you first acquired an eligible dependent. If you acquire a dependent while you are eligible you shall automatically become eligible with respect to such dependent.

(3) In the case of a Domestic Partner no earlier than provided for in Article I, Section 5, Part (4).

(4) Certain collective bargaining agreements require an election by the employee in order to provide coverage for the dependents of the employee. A list of these collective bargaining agreements is available from the Fund Office and shall be supplied upon request. If an employee is eligible pursuant to such a collective bargaining agreement and wishes dependent coverage then the employee, subject to the exception set forth below, must at the time of the employee's enrollment in the Plan enroll their eligible dependents and the dependent's coverage subject to enrollment must be continuous through the date they no longer qualify as the employee's dependent.

(a) Other Coverage: If the employee declines enrollment for their dependent upon the employee's initial eligibility under the collective bargaining agreement because that dependent has other health coverage the employee may subsequently enroll that individual as an eligible dependent only if the following conditions are met. First, at the time of the employee's initial eligibility the employee must notify the Fund in writing of the name of the dependent and the name of the Health Plan they are covered by. Second, within 30 days of that dependent losing that other coverage the employee must enroll the dependent in this Plan. At the time of this special enrollment the individual must meet the definition of a dependent under these Rules and Regulations. At the time of this special enrollment the employee must provide evidence of the dependent's prior health coverage and the date of loss of coverage.

(b) Subsequent Dependents: If, subsequent to the employee's initial enrollment, the employee has a new dependent as a result of marriage, birth, adoption, placement for adoption, placement for foster care or legal guardianship the employee may enroll the new dependent. However, the employee must apply for enrollment of the dependent within 30 days after the marriage, birth, adoption, placement for adoption, placement for foster care or appointment as legal guardian. At the time of this special enrollment the employee must supply proof of the date of the event giving rise to this special enrollment right.

(c) Notwithstanding the limitations of Sub-Parts (a), (b) and (c) if an employee has previously elected not to provide coverage for the employee's dependents, and the employee subsequently has a right to exercise their open enrollment privileges under the 12 month rolling open enrollment provisions of the Plan, the employee may elect to enroll previously unenrolled dependents as part of the open

enrollment process. No change in medical plan options is required in order to accomplish this enrollment of dependents. Coverage for such dependents shall be effective on the first day of the month following the month of submission of all required open enrollment materials. At the time of this enrollment those individuals enrolled must meet the definition of a dependent under these Rules and Regulations.

C. Termination of Dependents' Benefits

The benefits of any dependent will terminate on whichever of the following dates occurs first:

(1) The date the dependent ceases to be an eligible dependent.

(2) The date on which the dependent enters full-time military service.

(3) The date you cease to be in an eligible status.

(4) The date on which there are no funds available to provide benefits.

(5) In the case of a Domestic Partner on the earliest date provided for in Article I, Section 5, Part (4).

If you die or enter into full-time military service, the eligibility of your dependents will terminate on the last day of the calendar month in which you die or enter such service.

Section 8. ***Termination of Your Benefits***

Your benefits shall automatically terminate on the earliest of the following dates: (a) the date on which you enter full-time military service, or (b) the date you cease to be in an eligible status, or (c) the date on which there are no funds available to provide benefits. (For Continuation privileges see Article II, Section 1B(6) and the following Section 9.)

Section 9. ***Consolidated Omnibus Budget Reconciliation Act (COBRA)***

The Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, requires that Fund participants (covered employees and dependents except Domestic Partners) be allowed to continue their medical and dental coverage under the Fund at their own expense following certain qualifying events which result in a loss of coverage.

If your employment terminates or for any reason your hours are reduced so that you become ineligible for coverage, you and your eligible dependents may elect COBRA continuation coverage for up to 18 months from the date your coverage would otherwise have ended.

Effective January 1, 1997 if you, or an eligible dependent, are determined by Social Security to be disabled within 60 days of the date on which COBRA coverage commenced, the disabled individual is entitled to extend the regular 18 month COBRA continuation coverage to 29 months. Eligible dependents of the individual electing this coverage may also receive additional coverage during this special 11 month extension. The premium for the additional 11 months of extended coverage is 150% of the normal cost of that coverage. To be eligible for the special 11 month extension the disabled individual must notify the Fund within 60 days following the later of the date on which the individual receives the initial COBRA notice following a qualifying event or the date Social Security determines that the individual is disabled and in all events before the end of the initial 18 month period of COBRA continuation coverage.

Children born to you or placed with you for adoption during your COBRA continuation coverage are eligible to participate in your COBRA coverage, but there may be an additional premium required for their participation. Should you desire this additional coverage you must promptly notify the Fund Office at the time of birth or placement for purposes of adoption.

If you become entitled to Medicare while on COBRA continuation coverage which was elected following a termination of employment or a reduction in hours, your eligible dependents may elect to extend their initial

18-month COBRA continuation coverage period to 36 months from the date you initially became covered due to a COBRA election.

If your dependents lose coverage due to your death, your surviving spouse and other covered dependents may elect COBRA continuation coverage lasting for up to 36 months from the date their coverage would otherwise have ended.

If a child ceases to be eligible for benefits due to a loss of dependent status, that former dependent may elect COBRA continuation coverage lasting up to 36 months from the date his or her coverage would otherwise have ended.

If your spouse ceases to be an eligible dependent because of a divorce or legal separation, your former spouse may elect COBRA continuation coverage lasting for up to 36 months from the date your spouse's coverage would otherwise have ended.

A parent electing COBRA continuation coverage may elect continuing coverage which will include coverage for dependent children. An employee electing COBRA continuation coverage may elect continuing coverage which will also include coverage for the employee's lawful spouse.

Individuals who elect COBRA continuation coverage must pay the cost of that coverage. The COBRA continuation coverage premiums are adjusted annually by the Fund and reflect 102% of the cost of coverage as of the date the premiums are set for the coverage. If you are totally disabled and qualify for the special extension of an additional 11 months of coverage, the premium for the 19th through 29th months of the extended coverage will be 150% of the cost of that coverage.

COBRA continuation coverage terminates on the earliest of the following events: (1) The last day of the period for which COBRA continuation coverage may be elected. (2) The date a required COBRA payment premium due and payable is not received by the Fund. (3) The date all Fund-sponsored medical plans are terminated. (4) The date the individual receiving coverage pursuant to COBRA first becomes covered under another group medical plan which does not contain any exclusion or limitation with respect to any pre-existing condition of such person. This date may vary for different members of the same family. (5) The date the person on COBRA continuation coverage first becomes entitled to Medicare coverage. The right to COBRA continuation coverage terminates only for the person who becomes entitled to Medicare coverage. (6) For individuals who are receiving the special 11 month extended coverage period due to disability, the first day of the month that begins more than 30 days after such a person is no longer disabled. (7) The expiration of the applicable 18 month, 29 month or 36 month COBRA continuation period.

If your coverage ends because of the termination of employment or reduction of hours or because of your death, you or your dependents will receive information from the Fund explaining the rights to elect COBRA continuation coverage and an application for such coverage.

When coverage terminates because of a divorce, legal separation or because a dependent is no longer eligible, you and the former dependent are responsible for notifying the Fund within 60 days of the loss of coverage. The Fund will then transmit a notice of COBRA continuation rights and an application to these dependents losing coverage. If you fail to notify the Fund Office as herein provided, the Fund shall have the right to offset against future claims any amounts paid on behalf of dependents who were not eligible for benefits.

The materials transmitted by the Fund will explain the options available in terms of electing either core benefits or core and non-core benefits. The materials transmitted will also explain the application process and the premium rates applicable to coverages elected.

You will have at least 60 days in which to elect COBRA continuation coverage. If individuals who have lost coverage and are eligible for COBRA continuation coverage fail to make an election within the 60-day time period, rights to COBRA continuation coverage will be waived.

If at the time of your termination from employment or reduction in hours of employment, you were working for an employer whose collective bargaining agreement included the required contributions for Retiree

medical coverage, the election of COBRA continuation coverage may serve as a bridge in creating eligibility for Retiree coverage. In these situations, the period of COBRA coverage elected will be viewed as employment with an employer whose collective bargaining agreement does require contributions for Retiree Health & Welfare coverage.

If at the commencement of your COBRA continuation coverage you are covered by a region-specific Plan, such as an HMO that covers a limited geographic area, and you subsequently relocate to another area, you are entitled to transfer your coverage to another HMO program of the Fund or the Direct Pay Medical Plan. Under no circumstances would such a transfer prolong the period of your COBRA continuation coverage.

In addition to the COBRA coverage discussed above, the Trustees have agreed to maintain certain extended benefit programs established prior to COBRA for individuals meeting the eligibility standards of Article II, Section 1(B)(6). They are: (a) 3 months of continuation coverage without the payment of any contribution if coverage is lost due to the cessation of active work due to a disability; (b) for Direct Pay Medical Plan employees who are totally disabled upon the termination of coverage, 12 months of medical coverage only for the employee and only for the disabling condition. By electing the 3 month disability extension discussed immediately above, COBRA rights are not forfeited and full regular benefits are provided to the employee and eligible dependents. However, the 3 months of continued coverage will be credited against the maximum number of months available under COBRA. For example: COBRA continuation period is 18 months for termination of employment, and if a 3 month disability extension is elected, the COBRA continuation would be reduced to the 15 months following the expiration of the disability extension. IN THE EVENT YOU CHOOSE THE 12 MONTH DISABILITY EXTENSION (b) DESCRIBED ABOVE WHICH ONLY PROVIDES COVERAGE FOR YOU AND ONLY PROVIDES COVERAGE FOR YOUR DISABLING CONDITION AND REMAIN UNDER THE 12 MONTH EXTENSION PROGRAM FOR 60 DAYS WITHOUT MAKING A COBRA SELECTION AND WITHOUT YOUR SPOUSE AND/OR DEPENDENT CHILD(REN) MAKING SUCH SELECTION WITHIN THE SAME 60 DAY PERIOD, YOU AND THEY WILL HAVE FORFEITED COBRA CONTINUATION RIGHTS.

In order to assure receipt of COBRA materials and other announcements describing changes in the Plan, you and your dependents should advise the Fund of any and all changes in your address.

Your self-payment for COBRA continuation coverage is payable on a monthly basis. It is your responsibility to pay the self-payment directly to the Fund in a timely fashion. You must make your first payment within 45 days after the date that COBRA continuation coverage is elected. Your date of election is considered to be the date your Election Notice is postmarked, if mailed, and the date received by the Fund if your Election Notice is hand delivered. If your first payment for continuation coverage is not received within the 45 day period after the date of your election you will lose all continuation coverage rights under the Plan. You are responsible for making sure that the amount of your first payment is correct. You may contact the Fund Office to confirm the correct amount of your first payment.

After you make your first payment for continuation coverage, you will be required to make periodic payments for each subsequent coverage month. Periodic payments must be made on a monthly basis. Under the Plan, each of these monthly payments for continuation coverage is due on or before the first day of the month for which coverage will be provided. If you make periodic payments on or before the first day of the monthly period to which it applies, your coverage under the Plan will continue for that month without any break. The Plan will send periodic notices of payments due for each coverage month.

Although periodic payments are due on a monthly basis you will be given a grace period of 30 days after the first day of the monthly coverage period to make each periodic payment. Should you fail to make your payment on or before the first day of the month your coverage will be suspended during the 30 day grace period until payment is received. If you pay the periodic payments before the end of the applicable 30 day grace period your coverage will be retroactively reinstated to the first day of the monthly coverage period. The failure to make payments on a timely basis means that any claim you submit for benefits while coverage is suspended will be denied and will have to be resubmitted if your coverage is reinstated due to a timely payment during the grace period. If you fail to make a periodic payment before the end of the applicable grace period for that coverage period you will lose all rights to continuation coverage under the Plan.

Section 10*. Family Medical Leave Act*

The Family Medical Leave Act enacted by Congress in 1993 provides that in certain situations certain employers are required to grant leave to employees and that in such situations the employer is required to continue medical coverage for the employees. The federal legislation specifically provides that more liberal provisions of state law are permitted and also provides that more liberal provisions contained within collective bargaining agreements are permitted.

It is not the role of the Trustees or Fund to determine whether or not an individual employee is entitled to leave with continuing medical care under the federal statute, any state statute or the provisions of a collective bargaining agreement. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee and where applicable, the local union.

To the extent that employees are entitled to leave with continuing medical coverage pursuant to the federal act, state legislation or provisions contained within a collective bargaining agreement, the Fund will provide continuing medical coverage so long as required monthly contributions are received from the contributing employer. Rights under this section in no fashion affect rights under COBRA or rights to continuing medical care pursuant to the disability extension features contained within the Plan.

Section 11. *Health Insurance Portability and Accountability Act of 1996*

In 1996 Congress passed, and the President signed, a measure known as the Health Insurance Portability and Accountability Act of 1996. Various changes to COBRA which were effective January 1, 1997 are included within Article II, Section 9. This Plan is fully subject to the Health Insurance Portability and Accountability Act of 1996.

When you experience a qualifying event under this Plan, the Fund Office may transmit to you, along with your initial COBRA notice, a certification of the number of months for which you and your dependents have been eligible for benefits under this Plan. If you are eligible for coverage due to new employment, a copy of this certificate should be given to your new employer in order that you can become eligible for the greatest number of benefits due to employment as quickly as is possible. You and/or your new employer should contact the Fund Office if any additional information certifying your coverage under this Plan is required. As is the case under existing law, once you become eligible under another plan which has no pre-existing condition limitation which limits the coverage available to you, your rights to continue coverage under this Plan pursuant to COBRA terminates.

Section 12. *Coverage under the Women's Health and Cancer Rights Act*

The Fund's medical plan is required to provide benefits conforming to the Women's Health and Cancer Rights Act of 1998. The Act provides that a plan participant or beneficiary receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction will be provided with coverage in a manner determined in consultation with the attending physician and the patient for:

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

Section 13. *No Surprises Billing Act Claims, Benefits and Appeals*

(1) The provisions of this Section govern, 'Covered Claims' as defined below incurred on and after July 1, 2022.

(2) Covered claims are:
    (a) All out-of-network medically necessary emergency facility and professional medical expense;
    (b) Subsequent medically necessary post emergency care at out-of-network facilities until the patient can be safely transferred to a network facility;
    (c) All medically necessary air ambulance charges;
    (d) All medically necessary out-of-network services delivered at or ordered by an in-network facility or provider except for so-called, '72 hour excepted services' as described below and
    (e) Continuity of care medically necessary services and supplies for eligible patients as described below.

(3) The Plan, within 30 days of receipt of a medically necessary Covered Claim as described above, shall issue to the provider or provider's representative, payment equivalent to the median in-network PPO charge for the same medically necessary service or goods by or at network providers. In network deductible and co-payments apply. This median PPO charge shall be calculated by the Plan's PPO network provider.

(4) Except for regular out-of-pocket and deductible charges, providers of medically necessary Covered Claims as described above may appeal for further payment only from the Plan and only in conformity with applicable federal regulations governing the 30 day open negotiation, final offer and arbitration process of the federal No Surprises Act and related regulations.

(5) In general, if a provider or a facility ceases to be an in-network provider because of termination of contract, certain continuity of care protections apply to individuals who meet the definition of a continuing care patient and who are furnished items or services by the provider or facility for medically necessary services.

    When a provider's or facility's contract termination leads to a change in network status, the Plan will issue timely notification to each individual enrolled who is a potential continuing care patient of their termination and their right to elect transitional care from the provider or facility by completing and returning a required form. An individual so qualifying as a continuing care patient will be able to elect to have the same benefits provided under the same terms and conditions which would have applied under the Plan had the contract termination not occurred with the course of treatment furnished by the provider or facility subject to the following limitations. The election for continuing continuity care last until the earlier of 90 days from notification of termination or the date the individual is no longer a continuing care patient with the provider or facility.

    A continuing care patient is an eligible Participant or Dependent who is undergoing treatment from the terminated provider or facility for a serious complex condition which in the case of an acute illness is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm and in the case of a chronic illness or condition, is a condition that is life threatening, degenerate, potentially disabling or congenital and requires specialty medical care over a prolonged period of time. Alternatively, the continuing care patient must be undergoing a course of institutional or in-patient care from the provider or facility. Alternatively, the continuing care patient must be scheduled to undergo non-elective surgery from the provider or facility, including receipt of prospective postoperative care from such provider or facility with respect to such surgery. Alternatively, the continuing care patients will always include pregnant individuals undergoing treatment for pregnancy from the provider or facility. Continuing care patients will always include terminally ill individuals receiving medically necessary treatment for such terminal illness from the provider or facility.

    In no event shall an election by a continuing care patient for continuity care last longer than the earlier of 90 days or notification of the change in network status or the date when the individual is no longer a continuing care patient with the provider or facility.

(7) 72 hour exception services are not Covered Claims under this Section. Some but not all non-network providers may enter into agreements with eligible Participants and/or Dependents to provide services and bill the individual amounts in excess of the normal deductible and co-payments. Benefits for any such medical services are paid as non-network claims with no out-of-pocket annual maximum and may result in significant expense to the Participant and/or Dependent because the amount payable by the Plan will be significantly less than the payment by the Plan for a Covered Claim under this Section.

(8) The provisions of this Section to not apply to any claim payable under Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care or TRICARE.

(9) The No Surprises Act trumps any and all conflicting language found subsequently in the document.

Section 14. *Transportation Benefits*

If required non-emergency medical care is not available within 100 miles of the current location of an eligible individual requiring care, the Plan will provide reasonable and necessary travel expense reimbursements subject to IRS limitations. Round-trip transportation and lodging expense reimbursements are provided for the patient and one adult companion. Necessary airfare and/or train travel is limited to coach fare amounts. Necessary travel in a personal automobile is limited to then existing IRS medical mileage reimbursement rates. Necessary tolls, incidental cab fares, and parking fees may be reimbursed as well. Lodging reimbursements are limited to necessary nights not to exceed two nights and not to exceed $50 per night, per individual or such higher amount established by the IRS at the time. All reimbursements require completion of a necessary claim form with all amounts claimed by appropriate documentation. Transportation benefit claim forms are available from the Fund Manager. In all cases, any necessary transportation benefit shall be reimbursed and not advanced.

ARTICLE III
Enrollment for Medical Benefits

When you first become eligible, you may enroll yourself and your dependents under the Direct Pay Medical Plan described in this booklet, beginning on page 56. Alternatively, you may enroll in the HMO through Kaiser. The Direct Pay EPO Plan is not available to new participants. The plan you select will apply to you and all of your eligible dependents. Separate booklets are available which describe the benefits and coverage conditions for these plans. Contact the Fund Office to obtain one of these booklets.

You may change your coverage option after you have been covered by one medical plan option for at least 12 months. If you change your option, your new option will become effective on the first day of the month following receipt of your completed form at the Fund Office.

The following provides a brief description of the medical plans currently available from the Fund:

Direct Pay Medical Plan (PPO)

The Direct Pay Medical Plan provides you with freedom of choice in selecting a doctor. In order to maximize benefits, you must seek services from doctors and hospitals, which are part of the Anthem Blue Cross Prudent Buyer Network. The Prudent Buyer Network, called PPO for short, consists of all health care providers and facilities who are under contract with the Anthem Blue Cross Prudent Buyer Network and have agreed to reduced charges. This means lower out-of-pocket costs to you. When you use providers that are not in the PPO network, you may incur substantial out-of-pocket costs.

Kaiser Medical Plan (HMO) and Kaiser Senior Advantage (Medicare Retirees Only)

Please refer to the applicable Evidence of Coverage booklet for information about these plans.

Anthem Blue Cross (EPO) – Closed to New Enrollment

Please refer to the separate booklet for information about this plan.

UnitedHealthcare (Medicare Advantage) – Medicare Retirees Only

Please refer to the separate booklet for information about this plan.
Contact the Fund Office if you have any questions regarding your choice of health coverage.

ARTICLE IV
Medicare Provision

Section 1. ***Definition***

Whenever used in this Provision, the term ‘‘Medicare’’ refers to Health Insurance for the Aged as provided under both Parts A and B, Title XVIII of the Social Security Act, as amended from time to time.

Section 2*. Integration of Benefits with the Medicare Program*

For active eligible employees and their dependents, regardless of age, coverage under this Plan is usually primary to Medicare coverage. However, participants eligible for Medicare are encouraged to enroll in Parts A and B on the earliest possible date so that claims may be made for benefits not payable by the Fund.

For persons entitled to Medicare solely on the basis of End Stage Renal Disease (ESRD), this Plan is primary to Medicare for the first 30 months. Thereafter, Medicare becomes the primary payer and this Plan coordinates benefits with Medicare. You must enroll in Part A and Part B of Medicare when eligible.

IN ORDER TO NOT INCUR SIGNIFICANT OUT OF POCKET EXPENSES, ALL EMPLOYEES, RETIREES AND DEPENDENTS SHOULD ENROLL IN MEDICARE PART A AND PART B AS SOON AS THEY ARE ELIGIBLE FOR MEDICARE COVERAGE.

Section 3*. Retiree Medicare Provision*

If you are a Retired Participant age 65 or older you are eligible for Medicare and you must enroll in Part A and Part B of Medicare to be eligible for benefits from the Retiree Direct Pay Plan. If any of your dependents are eligible for Medicare they must enroll in Part A and Part B of Medicare to be eligible for benefits from the Retiree Direct Pay Plan. If you do not enroll in Part A and Part B of Medicare, the Plan will pay benefits as if Medicare had paid primary benefits, You will be responsible for your normal out of pocket costs plus all amounts that Medicare would have paid.

This same rule applies if you enter into a “Private Contract” with a provider in which you agree that the provider does not submit any of his/her charges to Medicare and you are responsible for the billed charges. All individuals over age 65 are typically eligible for Medicare but premium costs for coverage under Medicare may vary due to a lack of Medicare-Covered employment. If an eligible Retired Participant and/or their dependents do not enroll in Medicare, they will be permitted to enroll in the Kaiser HMO option if their residence permit it, however, additional charges from Kaiser will be added to the normal self-payment amount. This restriction does not apply to any Retired Participant without current Medicare coverage due to public employment who is enrolled in the Retiree Direct Pay Plan before January 1, 2021. This restriction also does not apply to any employee who has been continuously employed by the same state or local governmental employer since before April 1, 1986 and did not pay into Medicare, so long as the employer has been making contribution into this plan since January 1, 2015.

ARTICLE V
Coordination of Benefits

Section 1. *Benefits Subject to this Provision*

All of the benefits provided under these Rules and Regulations provision.

Definitions

‘‘Plan’’ means any plan providing benefits or services for or by reason of medical or dental care or treatment, which benefits or services are provided by (i) group, blanket or franchise insurance coverage; (ii) Blue Cross, Blue Shield, group practice, individual practice and other prepayment coverage; (iii) any coverage under labor-management trusteed plans, union welfare plans, employers' organization plans, or employee benefit organization plans; and (iv) any coverage required or provided by any statute except Title XVIII and XIX of the Social Security Act, as enacted or amended, except the term ‘‘Plan’’ shall not include (a) individual coverage and (b) group coverage paid for entirely by the individual.

The term ‘‘Plan’’ shall be construed separately with respect to each policy, contract, or other arrangement for benefits or services and separately with respect to that portion of any such policy, contract, or other arrangement, which reserves the right to take the benefits or services of other Plans into consideration in determining its benefits and that portion which does not.

‘‘This Plan’’ means that portion of Rules and Regulations which provides the benefits that are subject to this provision.

‘‘Allowable Expense’’ means any necessary, reasonable, and customary item of expense at least a portion of which is covered under at least one of the Plans covering the person for whom a claim is made.

Section 2*. Effect on Benefits*

If an Eligible Participant is entitled to benefits from another Group Plan for hospital, medical or surgical expense for which benefits are also due from this Plan, then the benefits provided hereunder will be paid in accordance with the following provisions, not to exceed, however, 100% of the expenses which are the Plan’s usual, customary and reasonable allowances.

(a) If the Eligible Participant is the Employee, Plan benefits will be provided without reduction.

(b) If the Eligible Participant is the Dependent lawful spouse of an Employee, Plan benefits will be paid for eligible expenses not covered by the other Group Plan.

(c) Except for cases of dependent children of divorced or separated parents, the health plan of the person whose birthday (month and day, not year) falls earlier in the calendar year will pay first and the plan of the other person covering the dependent will be the secondary payer.

If persons with the two plans covering the same dependent have the same birthday, the plan of the person which has had coverage longer is the primary payer.

(d) For children of divorced or separated parent, benefit payments are made by the plans in the following order:

(1) Parent with court-ordered financial responsibility for the child’s health care. If both parents have financial responsibility, the parent with custody pays first and the parent without custody is the secondary payor.

(2) Parent with custody.

(3) Spouse of the parent with custody.

(4) Parent without custody.

(5) Spouse of the parent without custody.

(e) The retired/laid off rule specifies that when a retired or laid off employee has two health plans because of coverage under a retirement health plan and as an active worker covered by another health plan, the plan covering the individual as an active employee will pay first and the plan of the company from which the worker is retired will pay second.

Section 3. ***Right to Receive and Release Necessary Information***

For the purpose of determining the applicability of and implementing the terms of this provision of this Plan or any provision of similar purpose of any other Plan, the Fund may, without the consent of or notice to any person, release to or obtain from any other insurance company or other organization or person any information, with respect to any person, which the Fund deems to be necessary for such purposes. Any person claiming benefits under this Plan shall furnish to the Fund such information as may be necessary to implement this provision.

Section 4. ***Facility of Payment***

Whenever payments which should have been made under this Plan in accordance with this provision have been made under any other Plans, the Fund shall have the right, exercisable alone and in its sole discretion, to pay over to any organization making such other payments any amounts it shall determine to be warranted in order to satisfy the intent of this provision, and amounts so paid shall be deemed to be benefits paid under this Plan and, to the extent of such payments, the Fund shall be fully discharged from liability under this Plan.

Section 5. ***Right of Recovery***

Whenever payments have been made by the Fund with respect to Allowable Expenses in a total amount, at any time, in excess of the maximum amount of payment necessary at that time to satisfy the intent of this provision, the Fund shall have the right to recover such payments, to the extent of such expenses, from among one or more of the following, as the Fund shall determine: Any persons to, or for, or with respect to whom such payments were made, any other insurance companies, or any other organizations.

Section 6. ***Benefit Credit Provision***

When this Plan is secondary and its payment is reduced because of the primary plan's benefits, a record is kept of the reduction. This amount will be used to increase this Plan's payments on the patient's later claims in the same calendar year, to the extent there are allowable expenses that would not otherwise be fully paid by this Plan and the others. This provision does not apply to your Dental Plan.

Subrogation Agreement

A. To the extent that the Teamsters Local Union No. 856 Health and Welfare Fund shall have paid any money to or on behalf of a participant pursuant to the provisions of the Plan of Benefits provided by the Fund, because of loss or damage for which the participant may have a cause of action against a third party who caused this loss or damage, this Fund shall be subrogated to the extent of such payment to any and all recovery by the participant and such right shall be assigned to the Fund as a condition of the payment of such money by the Fund.

B. In consideration of the payment, the participant must agree to assign and subrogate to the Teamsters Local Union No. 856 Health and Welfare Fund all of the rights, claims, interests or things in action and action at law, to the extent of the amount paid by the Fund which the participant may have against any party, person, firm or corporation, private or public, who may be liable, or may hereafter be adjudged liable for the loss and authorizes and empowers the Teamsters Local Union No. 856 Health and Welfare Fund to sue, compromise, or settle in the name of the participant or beneficiary and said Teamsters Local Union No. 856 Health and Welfare Fund is hereby fully substituted in the place of the participant and subrogated to all of the rights of such in the premises to the amount paid by the Fund.

The participant further agrees to execute any and all appeal bonds or other instruments in writing pertaining to any litigation arising out of losses herein above referred to, at the request of the Fund's representatives.

C. In the event a participant has settled an action or received judgment against a third party prior to submitting claims to Teamsters Local Union No. 856 Health and Welfare Fund and the claims reflect loss or damage allegedly caused by the third party, then benefits payable under the Plan of Benefits shall be reduced by all amounts paid by the third party pursuant to the settlement or judgment. If payment on the judgment or settlement has not been made, the provisions of Part B shall apply.

D. The rights of Teamsters Local Union No. 856 Health and Welfare Fund under this Subrogation Agreement shall have priority over the rights of a participant to be made whole for loss or damage caused by a third party.

E. The rights of Teamsters Local Union No. 856 Health and Welfare Fund under this Subrogation Agreement shall have priority over the rights of any and all attorneys retained by a participant.

F. Nothing in this Subrogation Agreement prevents a participant from assigning to the Teamsters Local Union No. 856 Health and Welfare Fund all causes of action against all third parties causing the loss or damage in which case benefits will be paid under the Plan of Benefits and the Teamsters Local Union No. 856 Health and Welfare Fund may pursue recovery of all benefits paid.

G. For purposes of this Subrogation Agreement, the term "participant" includes all eligible dependents of a participant.

H. The provisions of this Subrogation Agreement are severable and the invalidity of any part or provision shall not invalidate the balance of this Subrogation Agreement.

I. **No benefits subject to this Subrogation Agreement shall be payable unless the participant complies with all provisions of this Subrogation Agreement.**

J. In the event of breach of this subrogation agreement, Fund may withhold future benefits and/or pursue all other remedies.

In the November 1996 California General Election the Voters adopted Proposition 213 which eliminated the right of plaintiffs to recover general damages in certain situations. Liens of the Fund shall be reduced by 1/3 in those cases where the participant has no right to recover general damages due to the restrictions of Proposition 213.

ARTICLE VI
General Provisions

Section 1.

All Hospital benefits will be paid by the Fund to the Hospital and all other benefits to Eligible Participants as they accrue upon receipt of written proof, satisfactory to the Fund, covering the occurrence, character, and extent of the event for which the claim is paid.

Section 2.

Benefits payable hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person. However, any Eligible Participant may direct that benefits due him be paid to an institution in which he or his eligible Dependent is hospitalized or to any provider of medical services or supplies in consideration for medical or hospital services rendered or to be rendered, except as hereinafter provided. The Board of Trustees has determined that it is in the best interest of the Employees and Dependents to prohibit assignment of benefits to the following non-contract provider(s): SOAR Surgery Center LLC, its physicians and any of its other employees or agents. This prohibition on assignment is adopted pursuant to applicable law including, but not limited to, the Ninth Circuit decisions in Davidowitz v. Delta Dental Plan of California and Eden Surgical Center v. Braun Medical Inc. The restriction on assignments to the enumerated non-contract providers shall be subject to and construed in accord with any applicable federal law and/or regulation.

Section 3.

Benefits will be paid by the Fund only if notice of claim is made within 120 days from the date on which expenses with respect to which claim is made were first incurred unless it shall be shown by the Eligible Participant not to have been reasonably possible to give notice within such time limit, but in no event shall benefits be allowed if notice of claim is made beyond one year from the date on which expenses were incurred.

Section 4.

In the event the Fund determines that the Eligible Participant is incompetent or incapable of executing a valid receipt and no guardian has been appointed, or in the event the Eligible Participant has not provided the Fund with an address at which he can be located for payment, the Fund may, during the lifetime of the Eligible Participant, pay any amount otherwise payable to the Eligible Participant, to the spouse, or a relative by blood of the Eligible Participant, or to any other person or institution determined by the Fund to be equitably entitled thereto. In the event of the death of the Eligible Participant before all amounts payable under these Rules and Regulations have been paid, the Fund may pay any such amount to any person or institution determined by the Fund to be equitably entitled thereto. The remainder of such amount shall be paid to one or more of the following surviving relatives of the Eligible Participant: lawful spouse, child or children, mother, father, brothers or sisters, or to the Eligible Participant's estate, as the Board of Trustees in its sole discretion may designate. Any payment in accordance with this provision shall discharge the obligation of the Fund hereunder to the extent of such payments.

Section 5. *Claims and Appeal Rules*

A. First level appeals are handled by Anthem Blue Cross for the Direct Pay Plan, OptumRx for the prescription drug benefits, and Vision Service Plan for vision benefits. Following the first level appeal through the applicable entity, if there is a decision with which you do not agree, you may file a second level appeal with the Plan's Board of Trustees.

To appeal a determination from Anthem Blue Cross, send a written request to Grievances and Appeals, P.O. Box 4310, Woodland Hills, CA 91365-4310. Include any additional information you have that supports the request. You must ask for an appeal within 180 calendar days from the date of the determination.

To appeal a determination from OptumRx, send written comments, documents or other information to be considered to OptumRx, c/o Appeals Coordinator, P.O. Box 2975, Mission, KS 66201. You must file the appeal within 180 calendar days from the date of the determination.

To appeal a determination from VSP, request a grievance form from Member Services at (800) 877-7195 and mail the completed form, along with any written comments and supporting documentation, to VSP Vision Care, Attn: Complaint & Grievance Unit, P.O. Box 997100, Sacramento, CA 95899-7100, or fill out a grievance form online at vsp.com/contact-us/grievance. You must file your grievance within one year from the date of the determination.

Benefits provided by the Health Maintenance Organization (HMO) programs are subject to claims and appeal rules established by those providers. Life insurance benefits are insured and subject to the claim and appeal rules established by the insurer.

B. The following rules have been adopted by the Trustees to cover claims and appeals under the Direct Pay Medical Plan, the OptumRx Drug Program and the Vision Program. No Surprises Billing Act appeals are governed by the provisions of Article II Section 13.

It is the intent and desire of the Trustees that these rules be consistent and comply with applicable regulations, including but not limited to 29 CFR 2560.503 t. seq. These rules shall be construed in accord with that intent. Those regulations are incorporated here as though set forth in full. The regulations shall be construed in accord with the Department of Labor guidance issued subsequent to issuance of the regulations.

C. Pre-Service Claims

Pre-service Claims are claims for benefits which the Plan requires to be approved before you receive the actual medical care. There are instances under the Plan which require pre-authorization for claims. Such claims are described in the following sections of the Summary Plan Description; the Prior Authorization Review and Approval Program on page 58, and certain prescription drug benefits as described on page 73.

The Plan has contracted with Anthem Blue Cross to provide services to the Plan under the Prior Authorization Review and Approval Program and Second Surgical Opinion Program. The Plan has contracted with OptumRx to provide services to the Plan for the Prescription Drug benefits. Both providers utilize medical professionals to determine the appropriateness of requested care under these programs and to suggest, in some instances, alternatives. As more fully described in the SPD pages noted above these programs are initiated by your doctor or by you contacting the provider.

Under federal regulations the providers must respond within specific time frames to requests under these programs. For example, 15 days in cases involving routine pre-service care claims, 72 hours in pre-service care claims involving urgently required medical care and 24 hours in cases involving changes to previously approved plans of treatment. If your pre-service claim is not accompanied by necessary information, the provider will request additional information and these time periods will be extended as permitted by the federal regulations.

In rare instances you or your doctor may disagree with the decision of the provider under these programs. In such cases your doctor should immediately notify the appropriate provider that you wish to appeal the decision.

The provider must issue a decision on your appeal within specific time frames from receipt of your appeal. For example, within 30 days in appeals involving routine pre-service medical care claims, 72 hours in appeals on pre-service medical care claims involving urgently required medical care and within 24 hours in appeals involving changes to previously approved plans of treatment. The decision will be provided to you and the Board of Trustees. If the provider believes your appeal does not include all necessary information the provider will request additional information and these time periods will be extended as permitted by federal regulations.

These Pre-Service Claims and appeals involve issues predicated upon medical necessity and the appropriateness of requested care. While the Board of Trustees are the named fiduciaries responsible for the final determination of your pre-service appeal, the Board of Trustees does not possess the medical expertise of the medical professional employed by the providers or the outside independent medical review organizations utilized by the providers in cases of appeals. The Board has instructed the providers to adopt as the final decision on all appeals, the outside independent medical review organization decision which is most favorable to you.

While you will have exhausted the claims process required under the Plan by your appeal to these providers, you should not hesitate to advise the Board of Trustees in writing if you believe the final decision by either provider is not satisfactory.

D. Post-Service Claims

All claims for medical benefits under the Direct Pay Medical Plan, other than those described in Part B above are so-called Post-Service Claims. These claims are made by you or your doctor completing a claim form after the medical treatment is received and filing the claim form with the Fund Office. For example, if you have a routine visit to your physician a claim form is completed and filed with the Fund Office. These claim forms are available from the Fund Office. Except as described in Part B, your prescription drug benefit is a so-called card-based system and your claim is deemed made when you present the prescription and your OptumRx card to a participating pharmacist. Your vision service benefit is provided through VSP and a claim is made when a claim form is filed with VSP by you or the provider. These claim forms are available from VSP and the providers.

Within 30 days of filing of a post service claim to the extent that any portion of your claim is denied you will receive a notice of denial which identifies the specific Plan provisions upon which the denial is based. For example, your provider might include charges in excess of the definition of "Reasonable Charges or Expenses" as contained in the Plan in which case all charges in excess of the reasonable amount would be denied. As another example, in some cases not all of your claim will be paid because of copayment or deductible provisions contained within the Plan.

The 30 day period described above may be extended to the extent permitted by federal regulations if additional information is required to process your post-service claim. You will be notified what additional information is required in order to process your claim.

For the purpose of determining the legitimacy and/or necessity of a claim, the Plan may require medical records or proof of payment be submitted to support the services rendered.

If your post-service claim is denied, in whole or in part, you may file an appeal with the Board of Trustees. This appeal should be in writing and state in clear and concise terms your reason(s) for disputing the denial. Your appeal of any post-service claim denial must be transmitted to Northwest Administrators, Inc.

If your appeal is based upon an issue involving medical expertise, for example whether a particular service is medically necessary, the Trustees will obtain an independent expert medical opinion prior to consideration of your appeal.

The Trustees typically meet every even numbered month. If your appeal is received by the Fund Office at least 30 days in advance of a regularly scheduled meeting your appeal will be considered by the Trustees at the next regularly scheduled meeting. To the extent permitted by federal regulations consideration of your appeal may be put over to the next meeting of the Board if additional information is required. You will be notified in writing of any need for additional information.

To assure timely consideration of appeals the Board has established an Appeals Committee of one Union and one Employer Trustee. This Committee is empowered to make final decisions if required to timely deal with appeals, for example, when a regular Board meeting is canceled.

When the Committee or Board makes a final determination on your appeal you will be advised in writing of the determination by the Fund Office within five days of the decision.

E. Eligibility Issues

One aspect of both pre-and-post service claims is whether the individual is or is not eligible under the Plan at the time the services are requested or incurred. The Fund Office or the employer maintains all eligibility records and makes all initial determinations of eligibility. If you object to that determination, any appeal you might pursue related to that determination is handled by the Board or its Appeals Committee.

All determinations of eligibility are tied to the time frames which govern the balance of the claim. For example, the eligibility portions of a pre-service claim are governed by the initial determination and appeal time frames contained within the applicable provisions of Part B above. The initial eligibility determination and appeal portion of a post-service claim are governed by the time frames of Part C above.

F. Exhaustion of the Appeal Process

Under a Federal Law known as ERISA a participant or beneficiary whose claim for benefits has been denied may file suit against the Plan seeking the denied benefit. However, prior to filing such a suit the appeal process under the Plan described above must be pursued and exhausted. Thus, following any initial denial of benefits if you disagree it is important you file a timely appeal. In all cases your appeal must be filed no later than 180 days after the initial denial of your claim is received by you. If you do not file an appeal within the required time frame you will have failed to exhaust your appeal rights. The Trustees may extend the 180 day limit upon your showing good cause for the delay but to protect your rights you should file any appeal promptly after your receipt of the initial denial.

G. Some Questions Common to all Claims and Appeals

(1) Who may file an appeal if my claim is denied? You may file the appeal yourself or you may authorize a representative (i.e., doctor, spouse, etc.) to file an appeal on your behalf. Except in pre-service claim appeals where your doctor is acting as your representative, any representative acting on your behalf must have received written authorization from you to act on your behalf and that written authorization must be filed with the Fund Office as part of your appeal. If you are physically or mentally incapacitated the Trustees will waive this written authorization requirement. It is extremely important to understand that a mere assignment of benefits to the provider does not constitute an authorization for the provider to act as your representative.

(2) If my claim is denied will the Plan upon request supply me or my representative with all documents relevant to my claim? Yes. The Plan will upon request supply copies of documents and opinions relevant to your claim in accordance with federal regulations.

(4) May I seek prior approval from the Plan for medical care which is not governed by the pre-service provisions of the Plan and appeal any adverse determination under Part B of these Rules? No. Only claims for which pre-authorization is required under the Plan are subject to the expedited decision and appeal provisions of Part B.

(5) If my pre-service claim is denied, I receive the medical care despite the denial and then file a claim for the medical expense incurred, will this claim for medical expense be handled under the expedited provisions of Part B of these Rules? No. Once medical care has been provided the only issue is what, if any, portion of the bill will be paid and the provisions of Part C apply to the claim for medical expenses.

(6) If a previously approved course of treatment is changed by Anthem Blue Cross will the effective date of the change preclude my rights of appeal? No. The effective date of the change must give you the opportunity to appeal, for example at least 24 hours under Part B of the Rule.

(7) May the Plan and I mutually agree to extend the time frames contained in these rules? Yes.

(8) Who should I contact if I have questions about these claims and appeal rules? You should contact the Fund Office.

H. No Eligible Participant, eligible Dependent, beneficiary or other person shall have any right or claim to benefits under the Plan or any right or claim to payments from the Fund other than as specified in these Rules and Regulations, the rules of the Fund and the provisions of the Trust Agreement. Any dispute as to eligibility, type, amount or duration of such benefits or any right or claim to payments from the Fund shall be resolved by the Board of Trustees, or its Agents, under and pursuant to the Fund and the Plan and its decision of the dispute, right or claim shall be final and binding upon all parties thereto, subject only to such judicial review as may be in harmony with federal labor policy. The term ''Agent'' as used herein means any insurance company, insurance service, contract administrator or similar organization selected by the Board of Trustees to pay the benefits provided by the Fund or the Plan.

I. Any person whose application for benefits under the Plan has been denied in whole or in part by the Board of Trustees, or its Agent, or whose claim to benefits against the Fund is otherwise denied by the Board of Trustees, or its Agent, shall be notified in writing of such denial within 90 days from receipt of such claim. An extension of time not exceeding 90 days may be required by special circumstances. If so, notice of such extension, indicating what special circumstances exist therefore and the date by which a final decision is expected to be rendered, shall be furnished the claimant prior to the expiration of the initial 90 day period. The notice shall set forth in a manner calculated to be understood by the claimant: (1) the specific reason or reasons for the denial; (2) specific reference to pertinent Plan provisions on which the denial is based; (3) a description of any additional material or information necessary to perfect the claim and an explanation of why such material or information is necessary; and, (4) appropriate information as to the steps to be taken if the claimant wishes to submit his or her claim for review.

J. Any person may petition the Board of Trustees for review of the denial. A petition for review shall be in writing, and shall state in clear and concise terms the reason or reasons for disputing the denial. It shall be accompanied by any pertinent documentary material not already furnished, and shall be filed with or received by the Fund Office, or the office of the Agent, within sixty (60) days after the petitioner received notice of the denial. The petitioner or his duly authorized representative shall be permitted to review pertinent documents and submit issues and comments in writing.

K. Upon good cause shown, the Board of Trustees, or its Agent, shall permit the petition to be amended or supplemented and shall grant a hearing on the petition before a hearing panel consisting of at least one Employer Trustee and one Union Trustee to receive and hear any evidence or argument which cannot be presented satisfactorily by correspondence. The failure to file a petition for review within such sixty (60) day period or to appear and participate in any such

hearing shall constitute a waiver of the claimant's right to review the denial, provided that the Board may relieve a claimant of any such waiver for good cause if application for such relief is made within one year after the date shown on the notice of denial.

L. A decision by the Board of Trustees, or its Agent, shall be made promptly and not more than 60 days after the Board's receipt of the petition for review unless special circumstances require an extension of time for processing, in which case notice of such extension shall be furnished to the claimant prior to the expiration of the initial 60 day period. A decision shall be rendered as soon as possible, but not later than 120 days after receipt of the petition for review. The petitioner shall be advised of the decision of the Board of Trustees, or its Agent, in writing. The decision shall be written in a manner calculated to be understood by the petitioner and shall include a specific reason for the decision, as well as specific reference to the pertinent provisions in the Plan on which the decision is based.

M. The decision of the Board of Trustees with respect to petition for review shall be final and binding upon all parties, including the applicant, claimant or petitioner and any persons claiming for the applicant, claimant or petitioner, subject only to judicial review as provided in subsection A. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a ''participant'' or ''beneficiary'' of the Plan within the meaning of those terms as defined in ERISA.

Section 6.

The Fund, at its own expense, shall have the right and opportunity to examine the person of any Eligible Participant when and as often as it may reasonably require during the pendency of any claim, and also the right and opportunity to make 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.

Section 7.

The benefits provided by this Fund are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislations.

Section 8.

The provisions of these Rules and Regulations are subject to and controlled by the provisions of the Trust Agreement, and in the event of any conflict between the provisions of these Rules and Regulations and the provisions of the Trust Agreement, the provisions of the Trust Agreement shall prevail.

ARTICLE VII
Amendment and Termination

Section 1.

In order that the Fund may carry out its obligation to maintain, within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Eligible Participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time, but upon a non-discriminatory basis:

(a) To terminate or amend either the amount or condition with respect to any benefits even though such termination or amendment affects claims which have already accrued; and

(b) To alter or postpone the method of payment of any benefit; and

(c) To amend or rescind any other provisions of these Rules and Regulations.

ERISA INFORMATION

The following information, together with the information contained in this Booklet form the Summary Plan Description required by the Employee Retirement Income Security Act of 1974 (ERISA).

1. Name of the Plan.
Teamsters Local Union No. 856 Health and Welfare Fund.

2. Name and Address of Board of Trustees.
Board of Trustees
Teamsters Local Union No. 856 Health and Welfare Fund
1000 Marina Blvd Ste 400
Brisbane, CA 94005-1841

3. EIN and Plan Sponsor Number.
This Plan is filed with the Internal Revenue Service under No. 94-6123582. The Plan Number is 501.

4. Type of Plan.
Teamsters Local Union No. 856 Health and Welfare Fund is a collective bargained, jointly trusteed labor/management trust formed to provide Life Insurance, Accidental Death and Dismemberment, Medical, Dental, Prescription Drugs, and Vision Benefits for eligible employees, their dependents and retirees.

5. Type of Administration
The Board of Trustees has engaged Northwest Administrators, Inc. to perform the routine administration of the trust as a contract administrator.

6. Name, Address and Telephone Number of Administrator.
Board of Trustees
Teamsters Local Union No. 856 Health and Welfare Fund
1000 Marina Blvd Ste 400
Brisbane, CA 94005-1841
Telephone (800) 297-4595

7. Name and Address of Agent for Legal Service.
Northwest Administrators, Inc.
1000 Marina Blvd Ste 400
Brisbane, CA 94005-1841
Telephone (800) 297-4595

Legal process may also be made upon a Plan trustee.

8. Name, Title and Business Address of Each Trustee.

Union Trustees

Julie Wall
Co-*Chair*
c/o Teamsters Local No. 856
453 San Mateo Avenue
San Bruno, CA 94066

Peter Finn
c/o Teamsters Local No. 856
453 San Mateo Avenue
San Bruno, CA 94066

Mike Lagomarsino
c/o Teamsters Local No. 856
453 San Mateo Avenue
San Bruno, CA 94066

Susanna Farber
c/o Teamsters Local No. 856
453 San Mateo Avenue
San Bruno, CA 94066

Employer Trustees

Douglas Cornford
Co-Chair
c/o Northwest Administrators, Inc
1000 Marina Blvd Ste 400
Brisbane, CA 94005-1841

Bruce Conhain
c/o Northwest Administrators, Inc
1000 Marina Blvd Ste 400
Brisbane, CA 94005-1841

Austris Rungis
c/o Northwest Administrators, Inc
1000 Marina Blvd Ste 400
Brisbane, CA 94005-1841

9. A Description of the Relevant Provisions of any Applicable Collective Bargaining Agreement.

The Teamsters Local Union No. 856 Health and Welfare Fund was established and continued as prescribed in various collective bargaining agreements between the Teamsters Local Union No. 856 Freight Checkers, Clerical Employees and Helpers and various Employers and Employer Associations. You may obtain a copy of the agreement under which you work upon written request to the Fund Office. Copies are available for your examination at the Fund Office.

10. The Plan Requirements Respecting Eligibility for Participation and Benefits.

This Trust provides benefits under the specific provisions of the Rules and Regulations and applicable Insurance Policies for which the Trust pays the premiums. The Fund utilizes the Anthem Blue Cross Prudent Buyer PPO Network and a separate list of all PPO providers is available from the Fund Office, upon request, and without charge.

11. Termination of Individual's Life Insurance.

The Trust provides Life Insurance, and Accidental Death & Dismemberment benefits through insurance policies, for which it pays premiums. The insurance policy is the source of benefits. Conditions covering Individual Termination are contained in ''The Applicable Booklet'' and Article II, Section 8, Rules and Regulations, page 27, herein.

12. Source of Contributions.

Contributions for this Health and Welfare Fund are made by employers in accordance with the Collective Bargaining Agreements between Teamsters Local Union No. 856 and the individual employers and employer associations. The contribution is based on monthly rates.

13. Identity of any Organization through which Benefits are provided.

Teamsters Local Union No. 856 Health and Welfare Fund
1000 Marina Blvd Ste 400
Brisbane, CA 94005-1841
(800) 297-4595

Anthem Blue Cross
(800) 888-8288

Kaiser
(800) 464-4000

UnitedHealthcare Secure Horizons (Medicare)
(800) 624-8822

DeltaCare USA
(800) 422-4234

First Dental Health
(800) 334-7244

UHC Dental
(800) 999-3367

OptumRx
(800) 797-9791 (TTY711)

United American (Medicare Prescription Drugs)
(800) 353-6926

Vision Service Plan (VSP)
(800) 877-7195

Standard Life Insurance Company
(800) 628-8600

Teamsters Assistance Program (TAP)
(510) 562-3600

For benefits provided by Kaiser or under the Direct Pay EPO plans, please refer the applicable booklet.

14. Plan Year.

July 1 to June 30.
Fiscal Year-End Date: June 30.

15. Remedies available under the Plan for the Redress of Claims which are Denied in Whole or in Part.

A. Application for benefits may be made by completing the appropriate claim form(s). These forms may be acquired from Northwest Administrators, Inc. The completed form(s) should be returned to Northwest Administrators, Inc. who will verify your eligibility. The claim will be deemed to be filed when it is received by Northwest Administrators, Inc.

B. Appeals will be handled in accordance with Article VI, Section 5.

16. As a participant in Teamsters Local Union No. 856 Health and Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan participants shall be entitled to receive information about your plan and benefits.

Examine, without charge, at the Plan Administrator's office, all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor.

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 Administrator may make a reasonable charge for the copies of some of these documents.

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 at no cost to the participant.

Continue health care coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description for the rules governing your COBRA continuation coverage rights.

To the extent this Plan has any exclusionary periods of coverage for pre-existing conditions, reduction or elimination of those exclusionary periods if you have creditable coverage from another Plan. You should be provided a certificate of creditable coverage, free of charge, from your group health Plan or health insurance issuer when you leave coverage under that Plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or upon your request up to 24 months after losing coverage. Without evidence of creditable coverage you may be subject to any pre-existing condition exclusions for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

In addition to creating rights for Plan participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit Plan. The people who operate your Plan, called ''fiduciaries'' of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the Plan or exercising your rights under ERISA. If your claim for benefits is denied in whole or in part you must receive a written explanation of the reason for the denial. You have the right to have the Plan review and reconsider your claim. Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request materials from the Plan and do not receive them within 30 days, you may file suit in a Federal Court. In such a case, the Court may require the Plan Administrator to provide the materials and pay you up to $110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Group health plans and health insurance insurers generally may not, under Federal Law, restrict benefits for any hospital length of stay in connection with child birth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a caesarean

section. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or newborn earlier than 48 hours (or 96 hours) as applicable. In any case, Plans and insurers may not, under Federal Law, require that a provider obtain authorization from the Plan or the insurance issuer for prescribing a length of stay not in excess of 48 (or 96 hours).

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

NOTICES OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

The *Teamsters Local Union No. 856 Health and Welfare Fund and Plan* (the "Plan") is required by law to take reasonable steps to protect the privacy and confidentiality of your health information. This Notice describes the Plan's privacy practices. The term **"Protected Health Information"** (PHI), as used in this Notice, includes all individually identifiable health information transmitted or maintained by the Plan, regardless of form (oral, written, or electronic).

Uses and Disclosures of PHI

Uses and Disclosures to Carry Out Treatment, Payment and Health Care Operations

The Plan and its business associates will use PHI to carry out treatment, payment and health care operations.

Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers.

Payment includes but is not limited to actions to make coverage determinations and payment (including billing, claims management, subrogation, plan reimbursement, coordination of benefits, obtaining payment under a contract for reinsurance, (such as stop-loss and excess of loss insurance), precertification, reviews for medical necessity and appropriateness of care and utilization review and preauthorizations). For example, the Plan may tell a doctor whether you are eligible for coverage or what percentage of the bill will be paid by the Plan.

Health care operations include but are not limited to quality assessment and improvement, reviewing competence or qualifications of health care professionals. It also includes case management, conducting or arranging for medical review, legal services and auditing functions including fraud and abuse compliance programs, business planning and development, business management and general administrative activities. For example, the Plan may use information about your claims to audit the accuracy of its claims processing functions or to resolve a claim appeal you file. At no time and under no circumstances will the Plan use genetic information for underwriting purposes and/or determining premiums.

Uses and Disclosures That Require Your Written Authorization

Except as otherwise indicated in this Notice, uses and disclosures will be made only with your written authorization, subject to your right to revoke such authorization.

Uses and Disclosures That Require That You Be Given An Opportunity To Agree Or Disagree Prior To The Use Or Release

Disclosure of your PHI to family members, other relatives and your close personal friends is allowed if:

- The information is directly relevant to the family or friend's involvement with your care or payment for that care; and
- You have either agreed to the disclosure or have been given an opportunity to object and have not objected.

Uses and Disclosures For Which Authorization Or Opportunity To Object Is Not Required

Use and disclosure of your PHI is allowed without your authorization or request under the following circumstances:

- When required by law, or for law enforcement purposes.

- When permitted for purposes of public health activities.
- To a public health oversight agency for oversight activities authorized by law. This includes uses or disclosures in civil, administrative or criminal investigations; inspections; licensure or disciplinary actions (for example, to investigate complaints against providers or to investigate Medicare or Medicaid fraud).
- When required for judicial or administrative proceedings.
- To a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death or other duties as authorized by law.
- For research, subject to conditions.
- When authorized by and to the extent necessary to comply with workers' compensation or other similar programs established by law.
- Organ and Tissue Donation. If you are an organ donor, we may release your protected health 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.
- Military and Veterans. If you are a member of the armed forces, we may release your protected health information as required by military command authorities. We may also release protected health information about foreign military personnel to the appropriate foreign military authority.

Rights of Individuals

Right to Request Restrictions on PHI Uses and Disclosures

You may request the Plan to restrict uses and disclosures of your PHI to carry out treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified by you who are involved in your care or payment for your care. However, the Plan is not required to agree to your request. The Plan is required to comply with a restriction request if you request restricted disclosure of PHI for payment or health care operations purposes (not for treatment purposes) and the PHI at issue relates solely to a health care item for which you have paid the health care provider in full out of pocket.

Confidential Communications

You have the right to request to receive communications of PHI from the Plan either by alternative means or at alternative locations. For example, you may request that the Plan contact you at home, rather than at work. The Plan may agree to accommodate any such request if it is reasonable. The Plan, however, must accommodate such requests if you clearly state that the disclosure of all or a part of the PHI could endanger you.

Right to Inspect and Copy PHI

You have a right to inspect and obtain a copy of your PHI contained in a designated record set, for as long as the Plan maintains the PHI.

Designated Record Set includes the enrollment, payment, billing, claims adjudication and case or medical management record systems maintained by or for a health plan; or other information used to make decisions about individuals. Information used for quality control or peer review analyses and not used to make decisions about individuals is not in the designated record set.

Right to Amend PHI

You have the right to request the Plan to amend your PHI or a record about you in a designated record set for as long as the PHI is maintained in the designated record set. You will be required to make request for amendment in writing and to provide a reason to support a request for amendment.

The Right to Receive an Accounting of PHI Disclosures

At your request, the Plan will also provide you with an accounting of disclosures by the Plan of your PHI during the six years prior to the date of your request. However, such accounting need not include PHI disclosures made: (1) to carry out treatment, payment or health care operations; (2) to individuals about their own PHI; or (3) prior to the effective date of this Notice.

The Right to Receive a Copy of This Notice Upon Request

To obtain a copy of this Notice, contact the person or office identified in section 5 below.

Right to be Notified of a Breach

You have the right to be notified in the event that we (or a Business Associate) discover a breach of unsecured protected health information.

File a Complaint

You have the right to file a complaint if you believe that your privacy rights have been violated. You may complain to the Plan in care of the person or office identified below. Any complaint must be submitted in writing.

Northwest Administrators, Inc.
Attn: Thom Wagner
2323 Eastlake Avenue East
Seattle, WA 98102-3393
206-329-4900 or ***twagner@nwadmin.com***

You may also file a complaint with the Secretary of the U.S. Department of Health and Human Services or its OCR, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201. The Plan will not retaliate against you for filing a complaint.

The Plan's Duties

The Plan is required by law to maintain the privacy of PHI, to provide individuals (participants and beneficiaries) with notice of its legal duties and privacy practices, and to comply with the terms of this Notice.

This Notice is effective beginning August 1, 2016, however, the Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by the Plan prior to that date.

Minimum Necessary Standard

When using or disclosing PHI or when requesting PHI from another covered entity, the Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. However, the minimum necessary standard will not apply in the following situations:

- Disclosures to or requests by a health care provider for treatment;
- Uses or disclosures made to the individual;
- Disclosures made to the Secretary of the U.S. Department of Health and Human Services ("HHS") and its Office of Civil Rights ("OCR") or other authorized government organizations to determine if the Plan is handling PHI correctly.
- Uses or disclosures that are required by law; and
- Uses or disclosures that are required for the Plan's compliance with legal regulations.

In addition, the Plan may disclose your health information to the plan sponsor and to necessary advisors that assist the plan sponsor in performing plan administration functions, such as handling enrollment, eligibility and claim appeals. The Plan may also use or disclose "summary health information" to the plan sponsor for obtaining premium bids or modifying, amending or terminating the plan, which summarizes the claims history, claims expenses or type of claims experienced by individuals for whom a plan sponsor has provided health benefits; and from which identifying information has been deleted.

Notification of Breach of Unsecured PHI

No later than 60 days from the discovery of any Breach of Unsecured PHI, the Plan will provide you with notice of such Breach. Unsecured PHI includes PHI in electronic form that is not encrypted and PHI in paper form that has not been destroyed. A Breach of Unsecured PHI is an unauthorized acquisition, access, use or disclosure that compromises the security or privacy of such information such that there is a significant risk of financial, reputational or other harm to you as a result of the unauthorized acquisition, access, use or disclosure. However, an unauthorized acquisition, access, use or disclosure of Unsecured PHI will not be considered a Breach if it is within one of the following three exceptions: (i) an unintentional acquisition, access, use or disclosure of PHI by a workforce member of the Plan or one of its Business Associates if made in good faith and within the course and scope of employment so long as the information is not further acquired, accessed, used or disclosed by any person; (ii) an inadvertent disclosure by an individual who is authorized to access PHI at the Plan or a Business Associate to another person who is also authorized to access PHI at the Plan or the Business Associate if the information is not further acquired, accessed, used or disclosed without authorization; or (iii) an impermissible use or disclosure of PHI for which the Plan or its Business Associate has a good faith belief that the unauthorized individual who has obtained the PHI would not reasonably be able to retain it.

In the event of a Breach of Unsecured PHI, the Plan's written notification to you will include the following information: the date of the breach; the date of discovery of the breach; the type of PHI involved; the steps you should take to protect yourself from potential harm from the Breach; an explanation of what steps the Plan is taking to investigate the Breach, mitigate harm to you and to protect against further breaches; and contact procedures for you to obtain additional information. If the Plan lacks current contact information for you, it will provide substitute notice, which will be by email, telephone, or may be by other means including posting notice on the Plan's website or conspicuous notice in major print or broadcast media in the geographic area where you are likely to reside. In circumstances in which the Breach of Unsecured PHI is reasonably believed by the Plan to have affected more than 500 individuals in a particular state or jurisdiction, the Plan will provide additional notice to prominent media outlets within the state or jurisdiction no later than 60 days after discovery of the Breach. Finally, the Plan will report any Breach of Unsecured PHI to HHS as required by HHS.

Miscellaneous

Marketing

Although the Plan is allowed to use and disclose your PHI for marketing purposes with your written authorization, the Plan will not use and/or disclose your PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service. For example, sending a brochure detailing the benefits of an anti-depressant medication that encourages its use or purchase is considered marketing. However, the Plan may use your PHI without authorization in certain situations, including but not limited to sending you information describing the participating providers in its provider network(s) and the benefits provided under the Plan, providing information for the management of your treatment, or recommending alternative treatment, providers, or health coverage. Although these activities shall generally not be construed as marketing for purposes of the Privacy Rule, such activities will be construed as marketing if the Plan receives either direct or indirect payment in exchange for making such communications, except where each of the following conditions are met: (i) the communication describes only a drug or biologic that is currently being prescribed for the recipient of the communication; (ii) any payment received by the Plan in exchange for making the communication is reasonable in amount; (iii) the communication is made by the Plan or is made by one of its Business Associates in a manner allowed under its Business Associate contract; and (iv) the Plan receives a valid authorization from the recipient of the communication with respect to such communication.

Fundraising

To the extent the Plan provides you with any written fundraising communication that is a healthcare operation as defined under the Privacy Rule, it shall provide in a clear and conspicuous manner that you are entitled to elect not to receive any further such communication and such election shall be treated as a revocation of authorization.

Whom to Contact at the Plan for More Information

If you have any questions regarding this notice or the subjects addressed in it, you may contact the following officer:

Northwest Administrators, Inc.
Attn: Privacy Officer
2323 Eastlake Avenue East
Seattle, WA 98102-3393
206-329-4900 or ***twagner@nwadmin.com***

PHI use and disclosure by the Plan is regulated by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), the Standards for Privacy of Individually Identifiable Health Information ("Privacy Rule"), and the HITECH Act and its regulations. You may find the Privacy Rule at 45 Code of Federal Regulations Parts 160 and 164 subparts A and E. This Notice attempts to summarize the regulations. The law and its regulations will supersede any discrepancy between this Notice and the law and regulations.

THIS NOTICE OF PRIVACY PRACTICES IS INTENDED TO COMPLY WITH THE REQUIREMENTS SET FORTH IN HIPAA, THE PRIVACY RULE, THE HITECH ACT AND ITS REGULATIONS, AND ANY AMENDMENT THERETO. ANY OMISSIONS OR OVERSIGHTS SHALL BE RESOLVED IN ACCORDANCE WITH THE LAW AND ITS REGULATION(S).

DIRECT PAY MEDICAL PLAN BENEFITS
Preferred Provider Option (PPO) Plan
(For Active Employees and Non-Medicare Retirees/ Dependents of Retirees)

This section applies only to employees who are enrolled in the Direct Pay Medical Plan. If you are enrolled in the Kaiser or Anthem Blue Cross EPO medical plans, separate brochures are available which describe those benefits.

Introduction

Take the time to read this section carefully, so that you and your eligible dependents will know how to use the Direct Pay Medical Plan to your full advantage. By learning a few basics, your out-of-pocket costs will be substantially reduced.

The Board of Trustees has contracted with Anthem Blue Cross for the purpose of making their expansive Prudent Buyer Network of preferred providers available to employees and their eligible dependents who are covered under the Direct Pay Medical Plan.

Anthem Blue Cross has established a network of "Preferred Providers." These providers have agreed to participate in the Anthem Blue Cross preferred provider organization program, called PPO for short.

The Anthem Blue Cross PPO is called the Prudent Buyer Plan**.** Therefore, whenever you see the term Prudent Buyer just remember it is the Anthem Blue Cross PPO.

When you think of a PPO, you probably think of doctors and hospitals, which is correct. However, there are other health care providers, which are neither physicians nor hospitals. The Anthem Blue Cross Prudent Buyer Network includes an expanded list of providers in addition to doctors and hospitals. For example, ambulatory surgical centers, home health care agencies, home infusion therapy providers, skilled nursing facilities and medical products and services.

These Prudent Buyer preferred providers have agreed to provide health care for covered persons and accept the Plan's payment for a covered service plus the covered person's share of the covered charge (i.e. co-insurance, co-payment, penalty amount [if any]) as payment in full.

It is your responsibility to verify current Prudent Buyer status of the provider before you obtain services. Remember to ask your doctor if he/she is an Anthem Blue Cross Prudent Buyer Preferred Provider. You can also locate Prudent Buyer doctors online at ***www.anthem.com/ca*** or by calling the Fund Office.

The Fund Office will supply you with an identification card, which identifies you as being eligible to use the Anthem Blue Cross Prudent Buyer network of Preferred Providers. To be eligible for coverage you must work the required hours and be eligible for benefits as explained in the Eligibility section (Article II of the Rules and Regulations) beginning on page 15.

When you use a Prudent Buyer provider you will realize substantial savings and have less out-of-pocket expense as opposed to going to a non-preferred provider. This, in part, is because Anthem Blue Cross Prudent Buyer providers have agreed to provide health care at a reduced cost, and these savings are passed along to you.

Prudent Buyer vs. Non-Preferred Providers

When you use a Prudent Buyer provider you will be reimbursed, in most cases, at a greater percentage of charges then if you used a non-preferred provider. Also, these providers have agreed to provide services or supplies at a discounted fee so your out-of-pocket costs will be less.

When you use a non-preferred provider, you will be, in most instances, paying a larger part of the billed charges when using a non-PPO provider. Also, if your provider's billed charges are more than the usual, customary and reasonable fees, you will also be responsible for the difference.

In addition to receiving greater benefits when using a preferred provider there are also other advantages. The preferred provider (PPO) is responsible for filing claims directly with Anthem Blue Cross. In the reverse, if you use a non-preferred provider you may be required to pay the non-PPO provider in full, and submit your claims for reimbursement; the decision is up to the provider.

Under the Direct Pay Medical Plan, you have complete freedom of choice in where you obtain health care. However, it is to your financial advantage to use an Anthem Blue Cross provider, as well as to the financial advantage of the Plan. In the rare instance where you may be unable to utilize an Anthem Blue Cross provider, please contact the Fund Office for assistance.

To receive maximum benefits under the Direct Pay Medical Plan, it is imperative that you make certain you are using a Prudent Buyer provider for all hospital and doctor services.

Anthem Blue Cross Website

Participating health care providers in the Prudent Buyer network include hospitals, physicians, and laboratory and radiology facilities. From time to time providers are added or deleted from the network.

There is a quick and easy way to find participating Prudent Buyer health care providers – including doctors and hospitals. To find a provider, simply go to the Anthem Blue Cross web site and use the online provider finder resource.

Follow these easy steps to find a participating California provider:

- Go to ***http://www.anthem.com/ca/find-care***
- If you are a currently enrolled in the Direct Pay Plan, log in for a personalized search, or use your member ID for a basic search.
- If you are not currently enrolled in the Direct Pay Plan, click "Basic search as a guest".
    1. Select the type of plan or network: Medical Plan
    2. Select the state of California
    3. Select how you get health insurance: Medical (Employer-Sponsored)
    4. Select the plan or network: Prudent Buyer CA Only
    5. Click Continue
    6. Type of Provider – select a provider type (e.g., health facility, physician, specialist, etc.)
    7. Specialty (optional) – you may select a specialty to refine your search. To select multiple specialties, hold down the control key and click on each specialty name.
    8. Location or Name – enter location or name criteria. Receive your search results via a listing, map or downloadable directory.

Alternately to the above, you can:

- Inquire of a physician or other provider if he/she is an Anthem Blue Cross Prudent Buyer Provider.
- Contact the Fund Office at (800) 297-4595. Remember, **it is your responsibility** to make certain that you are receiving medical services from a Prudent Buyer provider.

Annual Deductible

The deductible is the amount of covered medical expenses you are responsible for paying before most medical benefits are available. See the Schedule of Benefits on pages 4 through 7 for the deductible that applies to your Plan.

Covered medical expenses applied against the deductible during the last three months of a calendar year will also be used to reduce the deductible for the next calendar year.

Copayment

Most Covered Expenses are subject to the annual deductible (described above) and the coinsurance percentages (described below).

However, for some Plans, physician office visits with a PPO provider are not subject to the annual deductible and coinsurance. Instead, you pay a flat dollar copayment amount per visit and the Plan pays the rest. See the Schedule of Benefits on pages 4 to 7 to see if this provision applies to your Plan.

Medical copayments made in a year do not apply towards meeting your annual deductible.

Coinsurance

After you have satisfied the annual deductible, the Plan will pay a percentage of Covered Expenses. As shown on the Schedule of Benefits (pages 4 to 7), the Plan's percentage reimbursement may differ depending on if a Prudent Buyer provider (PPO) or non-PPO provider is used.

Coinsurance amounts are based on:

- Contract rate for services or supplies provided by PPO providers; these amounts are negotiated by Anthem Blue Cross.
- Usual, Customary and Reasonable (UCR) fee for services or supplies provided by non-PPO providers. The Plan determines UCR amounts as described on page 70.

Annual Out-of-Pocket Maximum

Your annual out-of-pocket expenses for PPO network Covered Expenses will not exceed the maximum amount shown in the Schedule of Benefits (pages 4 to 7). The maximum amount includes only the percentage you pay for covered services received from a PPO network provider. The annual deductible and any copayments are not applied toward your out-of-pocket maximum.

Services received for a non-PPO provider, non-covered expenses and any penalty for not preauthorizing an inpatient admission or other services do not count toward your out-of-pocket maximum.

The calendar year total Out-of-Pocket Maximum shall never exceed one half of the Plan Year maximum under the Affordable Care Act then applicable to self only coverage or family only coverage as applicable in terms of all in-network services and out-of-network emergency services. There is no Out-of-Pocket Maximum whatsoever in terms of out-of-network non emergency services.

Prior Authorization Review and Approval Program

Inpatient Admissions

All non-emergency in-patient admissions to a hospital, skilled nursing facility or approved treatment facility must be approved (prior authorization) by Anthem Blue Cross **BEFORE** you are admitted. In the event of a medical emergency (requiring surgery or inpatient admission), you must notify Anthem Blue Cross within 48 hours of being admitted as an inpatient or as soon thereafter as possible.

These approval requirements will provide you with assurance that you are being treated in the most efficient and appropriate health care setting and can help manage the rising costs of health care.

The inpatient admissions approval program applies to the following:

- Pre-service review determines the medical necessity of scheduled non-emergency admission.
- Concurrent review determines whether services continue to be medically necessary and appropriate when pre-service review is not required or has been performed as required.
- Retrospective review is performed when Anthem Blue Cross has not been notified and therefore has been unable to perform the appropriate pre-service or concurrent review.

Also, Anthem Blue Cross will perform a retrospective review of the inpatient stay and no Plan benefits will be provided for any inpatient days which are determined to not be medically necessary.

Other Services

In addition to review for all inpatient services, prior approval by Anthem Blue Cross is required for certain other services. If prior approval is not obtained for the following services, benefits may be denied in whole or in part based on a retrospective medical review giving consideration to medical necessity and that the charges incurred are for a covered service:

- Transplants
- Home health care
- Hospice care
- Home infusion therapy
- Potentially cosmetic/investigative services
- Certain durable medical equipment or prosthetics

Prior approval determines only the medical necessity of a specific service and/or an admission and an allowable length of stay. Prior approval does not guarantee your eligibility for coverage. Eligibility and benefits are based on the date you receive the services. An approval does not guarantee payment or that you will receive the highest level of benefits. For example, services not listed as covered, services received after you lose eligibility under the Plan and services that are not medically necessary will be denied.

Generally, Anthem Blue Cross Prudent Buyer providers will obtain prior approval in which case prior approval is not your responsibility. On the other hand, it is your responsibility to make certain than all non-preferred providers obtain prior approval before services are rendered.

Contact Anthem Blue Cross at (800) 274-7767 for all prior authorization reviews.

Covered Expenses

This section describes the services and supplies covered by the Direct Pay Medical Plan. All covered expenses are subject to the deductible, co-insurance and out-of-pocket limit provisions of the Plan.

Also, please refer to the Direct Pay Medical Plan Exclusions section, beginning on page 67.

Acupuncture Treatment

- Acupuncture visits performed by an accredited L.Ac or O.M.D. for service related to a covered diagnosis are covered up to 15 visits per calendar year.

Ambulance Services

- A specially designed and equipped vehicle used only for transporting the sick and injured. It must have customary safety and lifesaving equipment such as first-aid supplies and oxygen equipment. This vehicle must be operated by trained personnel and licensed as an ambulance.
- Necessary ambulance services in an emergency (e.g., cardiac arrest, stroke) to and from the nearest hospital providing emergency treatment.
- If you are treated as an outpatient for accidental injury or emergency illness provided within 24 hours after your accident, the Plan pays benefits for ambulance service.
- Air ambulance covered only when terrain, distance or your physical condition requires the use of air ambulance services.
- Hospital to hospital transfers will be covered if medically necessary (e.g. higher level of care is needed).
- Out-of-network non-air ambulance services shall be paid at the higher of:
  (1) the average amount which would be paid to an in-network provider for the same service;
  (2) the amount which would be paid under the UCR formula without reduction for out-of-network cost sharing generally applicable under the Plan;
  (3) the amount which Medicare would pay for the service excluding any in-network co- payment or co-insurance imposed with respect to the Participant or Beneficiary.

  It is the intent of the Trustees that out-of-network emergency services at all times be paid consistent with the requirements of applicable regulations including but not limited to 29 C.F.R. 2590.715-2719 A(b).

Ambulatory Surgical Facility

- Services and supplies provided by an ambulatory surgical center in connection with outpatient surgery.

Blood

- Blood transfusions, including blood processing and the cost of un-replaced blood and blood products.
- Charges for the collection, processing, and storage of self-donated blood are covered, but only when specifically collected for a planned and covered surgical procedure.
- The Direct Pay Medical Plan does not cover blood replaced through donor credit.

Chemical Dependency/Substance Abuse Treatment

- Outpatient services are covered the same as any other outpatient physician service.
- Inpatient treatment in a hospital or approved treatment facility is covered in the same manner as any another inpatient hospital stay and is subject to the prior authorization requirements of the Plan (see page 58). Inpatient treatment is limited to Certified Addiction Rehabilitation Facilities (CARF) or facilities that have been certified by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Chemotherapy and Radiation Therapy

- Treatment of malignant disease by standard chemotherapy and treatment of disease by radiation therapy

Chiropractic Treatment

- For outpatient and non-hospital chiropractic care by a licensed chiropractor (D.C.), the Direct Pay Medical Plan pays for necessary care, up to a maximum of 40 visits per calendar year. Necessary care includes manipulation performed by a chiropractor as well as massage therapy. Services rendered by a massage therapist are not covered.

Cochlear Implants

- Cochlear implants for the treatment of a congenital defect are a covered expense.

Dental Care

Charges for treatment performed on, or diagnosis of, the teeth, gums, mouth or adjacent structures will be included only if incurred for:

- a fractured jaw.
- damage to sound, natural teeth, if the damage results from an injury suffered while eligible. But treatment must begin within 90 days after the injury and all charges must be incurred within 1 year of the injury. A chewing injury will not be deemed a covered dental injury.
- a biopsy.
- excision of a tumor, cyst, or a foreign body.
- surgical removal of impacted teeth.
- excision of tori.
- removal of salivary stones.
- orthognathic surgery.
- temporomandibular joint disorder (TMJ).

Facility and anesthesia charges for children up to age 7 or for an incapacitated child may be also covered, based on the severity and complexity of the required dental work.

As covered dental work and oral surgery, a duly licensed dentist or oral surgeon is deemed to be a physician.

Diagnostic X-ray and Lab Services

- Outpatient diagnostic procedures such as laboratory and pathology tests, x-ray services, EKGs and EEGs that are ordered by a physician to determine a condition or disease.
- Outpatient diagnostic imaging services such as CT scans and MRIs ordered by a physician to determine a condition or disease may be subject to a review for medical necessity.
- Through November 11, 2023, COVID-19 tests are covered at 100% for both PPO and non-PPO providers. This includes both the cost of the test as well as office visits or other provider charges related to the testing. There will be a temporary suspension of prior authorization requirements for COVID-19 testing.

Durable Medical Equipment (DME)

- Rental (not to exceed purchase price) or purchase of durable medical equipment is a covered expense provided it is:
  - Of no further use when medical needs end;
  - For the exclusive use of the eligible patient;
  - Not primarily for comfort or hygiene;
  - Not for environmental control or for exercise; and
  - Manufactured specifically for medical use.

  The Board of Trustees will determine whether the item satisfies the conditions above. Replacement of equipment that has been lost, abused, or neglected is not a covered benefit.
- Rental or purchase of dialysis equipment, dialysis supplies, casts, splints, trusses, braces, crutches, wheelchair, hospital-type bed, and similar equipment when medically necessary and prescribed by your doctor.
- Maintenance of durable medical equipment is not a covered expense.

Flu Shots

- Flu shots received at a pharmacy or workplace are eligible for reimbursement under the Plan. Copies of the receipts must be submitted to the Fund Office for reimbursement.

Gene Therapy

Benefits for FDA approved, medically necessary Gene Therapy shall be covered on a similar basis as all other medical benefits. Gene Therapy benefits require pre-certification.

Habilitative Care

Habilitative care refers to health care services that help you keep, learn or improve skills and functioning for daily living. Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical, speech and occupational therapy and other services for individuals with other disabilities in a variety of inpatient and/or outpatient settings.

Hearing Aid

Hearing aids will be paid at 80% of usual, customary and reasonable fees, up to $2,000 per ear in any three-year period including the hearing aid(s), the cost of a hearing exam, and the fitting or repair of the hearing aid(s). Reimbursement of hearing aids purchased at an “over the counter” provider is only allowed with a prescription.

Home Health Care in Lieu of Inpatient Confinement

Home health care services provided by a home health care agency licensed by the State, are covered only when pre-approved by Anthem Blue Cross and take the place of confinement in a hospital, approved treatment facility or skilled nursing facility. Home health care provides certain benefits for medical services and supplies furnished on a visiting basis in a private residence to treat bodily injury or disease. After Anthem Blue Cross pre-approves home health care, Anthem Blue Cross will monitor this care to determine the continuing need for these services. A maximum of 100 home health visits per calendar year are covered by the Plan. Covered services include visits by a nurse, home health aid, physical therapist, occupational therapist and speech therapist.

Home health care benefits do not cover custodial care including but not limited to, items such as bathing, feeding, administering oral medications, and exercising. These benefits are not available to a person who lives with the eligible individual or is a member of the eligible individual’s family.

Hospice Care

Services for hospice care are a covered expense for a terminally ill covered person who does not have a reasonable prospect for cure and who has a life expectancy of 6 months or less, as certified by the attending physician. A hospice care program means a coordinated plan of inpatient and home health care which treat the terminally ill person and family as a unit. Care must be provided by a team made up of medical personnel, counselor, and other individuals with special training and can include homemakers who work in conjunction with the hospice care program. Covered services include the following.

- Inpatient care, including semi-private room and board, doctor's services, inpatient skilled nursing care, respiratory therapy, life support systems, pain therapy, drugs and medicines, psychological counseling, and spiritual support.
- Outpatient hospice care including nursing care given at home, visits by hospice staff personnel, physical and respiratory therapy, oxygen and the rental of medical equipment for the patient's care, medicine and drugs, and homemaker services.
- Professional counseling sessions with the patient and/or family members during the period of hospice care.
- Bereavement counseling sessions with the patient's family members for help in coping with the death of the patient within 90 days following the patient's death.

Hospital - Inpatient Services

- Regular room and board (including all medically necessary ancillary services) in an accredited hospital. For non-PPO hospitals the includable room and board charges may not exceed the hospital's regular rate for semi-private accommodations whether or not a semi-private room is available.
- Intensive care unit charges.
- Coronary care unit charges.
- Anesthetic supplies furnished by the hospital.
- Surgical supplies, dressings, and cast materials.
- Drugs and oxygen.
- Blood and plasma which are not replaced.
- X-rays and laboratory tests directly related to the sickness or illness for which you are hospitalized.

Inpatient hospital services are subject to the prior authorization requirement of the Plan (see page 58).

Hospital - Outpatient Services

- Hospital emergency room services and supplies
- Use of hospital room for outpatient surgery.
- Outpatient treatment in a hospital or approved treatment facility is covered in the same manner as any other hospital or approved treatment facility.
- Pre-admission diagnostic test within seven days of being admitted to the hospital or having outpatient surgery.

Immunizations

- See Preventive Care Services on page 65.

Infertility

- Covered charges for infertility are limited to initial diagnostic tests furnished in connection with infertility including doctors' services and all necessary laboratory expense.

Mastectomy Related Services

The Plan covers:

- All stages of reconstruction of the breast on which the mastectomy has been performed;
- Surgery and reconstruction of the other breast to produce a symmetrical appearance; and
- Prostheses and physical complications in all stages of the mastectomy, including lymphedemas; in a manner determined in consultation with the attending physician and the patient.

Maternity

Related expenses, including pregnancy, childbirth, miscarriage, or abortion, are covered like any other medical condition for the employee, spouse and eligible dependent children. In accordance with federal law, the Direct Pay Medical Plan does not restrict lengths of hospital stays for a mother or newborn to less than 48 hours following normal vaginal delivery or 96 hours following cesarean delivery. In consultation with your physician, you may choose not to stay the full 48/96 hours. The length of inpatient care may, however, be extended upon application of the mother's or newborn's attending physician to the Plan provided that the Plan determines that the extended stay is medically necessary.

Mental Health Treatment

- Inpatient treatment in a hospital or approved treatment facility is covered in the same manner as any other hospital stay and is subject to the prior authorization requirement of the Direct Pay Medical Plan (see page 58).

- Outpatient services are covered the same as any other outpatient physician service under the Direct Pay Medical Plan.

Nursing Care

- Charges for registered graduate nurse (R.N.) provided the services are usual-customary prescribed by the attending physician. There is no coverage for a nurse who resides in your home or who is related to you by blood or marriage. Private duty nursing is not a covered expense.

Nutritional Counseling

- Charges incurred in connection with nutritional counseling are covered if recommended and supervised by a physician and performed by a registered dietician or certified nutritionist. Benefits for services rendered by a PPO provider are payable at 100%. Benefits are limited to $100 in any covered individual's lifetime if a non-PPO provider is utilized.

Occupational Therapy

- Occupational therapy is covered when prescribed by and under the direct care of a medical doctor (M.D.). A copy of the prescription for services from the referring physician must be provided to the Fund Office upon request for charges to be considered.

Organ and Tissue Transplants

- Prior approval must be obtained from Anthem Blue Cross before a pre-transplant evaluation is scheduled. A pre-transplant evaluation may not be covered if prior approval to receive the services is not obtained from Anthem Blue Cross.
- Services provided in connection with a non-investigative organ or tissue transplant, if you are the organ or tissue recipient or donor.
- If you are the recipient, the organ or tissue donor who is not a covered person is also eligible for services as described. Benefits are reduced by any amounts paid by that donor's own coverage.
- Services must be provided at an approved transplant facility.
- Organ acquisition or procurement costs for the surgical removal, storage and transportation of an organ acquired from a cadaver. If there is a living donor that requires surgery to make an organ available (kidney or liver), coverage is available only for expenses incurred by the donor for surgery, organ storage expenses and inpatient follow-up care.
- No coverage is available for donor expenses after the donor has been discharged from the transplant facility.

Physical Therapy

- Physical therapy rendered by a covered provider must be prescribed by and under the direct care of a medical doctor (M.D.). A copy of the prescription for services from the referring physician must be provided to the Fund Office upon request for charges to be considered.

Physician Services

- Physician charges are covered for visits at the physician's office, hospital, and your home when medically required.
- No physician visits are payable for treatments given by the operating physician on or after the day of a surgical procedure and within the follow-up days stipulated for the surgery performed.

Note: Physician means more than an M.D. Certain other practitioners are included in this term as it is used throughout the Direct Pay Medical Plan. This does not mean they can provide every service that a medical doctor could; it just means that the Plan will cover expenses you incur from them when they are practicing within their specialty, provided the service they provide is a covered benefit under the Plan. As with other terms, be sure to read the definition of physician in the Definition section (beginning on page 10) to determine which providers' services are covered.

Podiatry

- Medically necessary services by a podiatrist for treatment of an illness or injury.
- Routine and cosmetic foot care, such as callus or corn paring or trimming of toe nails, is not covered.

Preventive Care Services

Preventive care services performed on an outpatient basis by a PPO network provider are covered at 100%, with no deductible or coinsurance. Covered services include:

- Preventive care services and screenings per the US Preventive Services Task Force (USPSTF) A and B recommendations. Covered procedures include such services as blood pressure and cholesterol screening, various cancer and sexually transmitted infection screenings. A complete list of these services and screenings can be reviewed at ***www.uspreventiveservicestaskforce.org/recommendations***.
- Routine immunizations as recommended by the Advisory Committee on Immunization Practices (ACIP) and published in the Centers for Disease Control (CDC) annual immunization schedules for children and adults. Current ACIP recommendations and immunization schedules can be found at ***www.cdc.gov/vaccines***.
- Preventive care services and screenings for infants, children and adolescents as recommended by the Health Resources and Services Administration (HRSA).
- Preventive care services and screenings for women recommended by the Health Resources and Services Administration (HRSA). A complete list of these services can be reviewed at ***www.hrsa.gov/womensguidelines.***

Preventive care services performed on an outpatient basis by a non-PPO network provider will be paid in accordance with the Schedule of Benefits and limited to the following services:

- Mammogram for breast cancer screening or diagnostic purposes: (a) a baseline mammogram for women ages 35 through 39; (b) every two years (or more frequently is recommended by the woman's physician) for women ages 40 through 49; (c) every year for women age 50 and older.
- Charges for an annual cervical cancer screening test.
- Charges associated with the vaccination for shingles.
- Immunizations for preventive child care for a dependent child from birth through age 16 at appropriate age intervals, based on Guidelines for Health Supervision of Children and Youth, and adopted by the American Academy of Pediatrics. Covered charges will be limited to all services provided in connection with a single physician's visit for each preventative care examination, including appropriate immunizations.

If you have any questions about what is covered under the Plan's preventive care benefit, please contact the Administrative Office.

Prosthetic Devices

When medically necessary and ordered by a physician the Direct Pay Medical Plan covers the following items:

- Breast prostheses following a mastectomy.
- Prosthetic devices to restore a method of speaking when required as a result of a medically necessary laryngectomy.
- Other medically necessary prosthetic devices including surgical implants and artificial limbs or eyes.
    - o Replacement of items only when required because of wear (an item cannot be repaired) or because of a change in your condition.
- Functional orthotics only for individuals having a locomotive problem or gait difficulty resulting from mechanical problems of the foot, ankle or leg.

- When alternate prosthetic devices are available, the allowance for a prosthesis will be based upon the least costly prosthetic device available.

Rehabilitative Care

Health care services that help you keep, get back, or improve skills and functioning for daily living that have been lost or impaired because you were sick, hurt, or disabled. These services may include physical and occupational therapy, speech-language pathology, and psychiatric rehabilitation services in a variety of inpatient and/or outpatient settings.

Skilled Nursing Facilities

- Skilled nursing facilities are facilities that primarily provide convalescent care for patients transferred from accredited general hospitals.
- The confinement must be ordered by a physician to convalesce from an injury or illness.

Speech Therapy

- Speech therapy is covered when prescribed by and under the direct care of a medical doctor (M.D.). A copy of the prescription for services from the referring physician must be provided to the Fund Office upon request for charges to be considered.

Surgery

Surgical services for medically necessary surgeries resulting from an illness or injury, including surgical procedures performed in a hospital, at a physician's office or elsewhere. If you are hospitalized, surgical benefits are in addition to the Plan's hospital benefits.

Assistant surgeon services are covered, up to 20% of the primary surgeon's covered charge, for a surgical procedure performed by an assistant surgeon or assistant physician (other than a hospital intern or resident) when medically necessary.

Second surgical opinions help you understand surgery risks and alternatives. The Plan covers a second surgical opinion for non-emergency procedures; a third surgical opinion is also covered if the first two opinions do not agree.

Robotic Assist charges billed by a PPO provider will be considered an eligible expense; Robotic Assist charges billed by a non-PPO provider are not covered under this Plan.

Multiple surgical procedures performed at the same time, whether related or not, are limited as follows:

- Up to 100% of the covered charge is allowed for the primary procedure.
- For subsequent procedures, up to 50% of the covered charge is allowed for each additional procedure.

Telehealth

Telephonic or videoconference visits with a Physician by are paid as any other office visit.

Vision

Vision related services with a medical diagnosis will be considered a covered expense under the Medical plan. Charges for determination of refractive state are not eligible under this provision.

Weight Loss Surgery

Services for weight loss surgery (bariatric surgery) are covered if necessitated as the direct result of a medically identified and diagnosed condition of disease origin. Prior approval from Anthem Blue Cross is required (see page 58).

Well Baby and Well Child Care

See Preventive Care Services (page 65).
Note: Routine newborn circumcision is a covered expense.

Medical Exclusions

No benefits are payable for:

1. Services, supplies, and treatment not prescribed by a legally qualified physician or surgeon;

2. Services, supplies or treatment not medically necessary for treatment of injury or illness (except as otherwise specifically provided);

3. Charges in excess of usual, customary and reasonable fees as defined by the Plan;

4. Charges which you or your dependents are not legally required to pay, or would not be required to pay in the absence of this Plan;

5. Claims not submitted within 12 months after expenses were incurred, except in the absence of legal capacity;

6. Charges assessed for the completion of claim forms or obtaining medical records;

7. Charges for missed or broken appointments;

8. Procedures which are considered experimental or which are not in accordance with generally accepted medical standards in the United States;

9. Donor's expenses, including testing, relating to any transplant procedure, unless the organ recipient is covered under this Plan and such expenses are not covered under the donor's insurance or any other program;

10. Organ transplants, including bone marrow transplants, unless approved in writing, in advance, by the Plan's Prior Authorization Review and Approval Program;

11. Services rendered outside of the United States, unless such services would have been covered if provided in the United States;

12. Services related to vision; exams to determine the need for or changes to eyeglasses or lenses of any type; eyeglasses or lenses except initial replacements for loss of natural lens; or eye surgery (such as radial keratotomy or LASIK surgery) to correct myopia (near sightedness), hyperopia (far sightedness) or astigmatism (blurring). Benefits may be available if services are on account of accidental bodily injury sustained while covered under this Plan;

13. Orthoptics and vision training;

14. Professional or other services from a person who lives with the patient or is related to the patient or the patient's spouse;

15. Benefits will only be paid for charges by a Physician who is present and consults with the Covered Person. Benefits will not be paid for charges for services of a physician, registered nurse (R.N.), licensed practical nurse (L.P.N.) or other licensed health care provider:

    (a) Who usually resides in the same household with the Covered Person; or

    (b) Who is related by blood, marriage, or legal adoption to the Covered Person or to the Covered Person's spouse.

16. Personal comfort, beautification, or convenience items or services;

17. Cosmetic surgery and any complications resulting there from, unless required for:

(a) Accidental injuries occurring while covered, and only if performed while still covered; or

(b) Reconstructive surgery when the service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part; and,

(c) Reconstructive surgery because of congenital disease or anomaly of an eligible dependent child which has resulted in a functional defect.

18. Any treatment of obesity, or services and supplies primarily for weight loss or control, unless necessitated as the direct result of a specifically identified and diagnosed condition of disease origin; gastric bypass or gastric stapling procedures, except as specifically indicated in the Plan and authorized as medically necessary by Anthem Blue Cross

19. In-vitro fertilization, artificial insemination, infertility treatment or any charges associated with the direct inducement of pregnancy (however, necessary services and supplies to diagnose infertility are covered);

20. Expenses related to conception, pregnancy or delivery in connection with a surrogacy arrangement;

21. Reversal of sterilization procedures;

22. Penile implants and any complications resulting there from, unless required as a result of injury or an organic disorder;

23. Incontinence supplies;

24. Professional services, except as specifically provided herein, rendered for behavioral characteristics, or vocational testing or counseling;

25. Treatment for learning disabilities; educational or social problems; therapy or surgery for sexual dysfunction or inadequacies, or psychiatric admissions which are primarily to control or change the patient's environment, except as specifically provided;

26. Sexual dysfunction treatment except for conditions of organic origin where the cause is documented by the attending physician;

27. Treatment for dyslexia;

28. Orthopedic shoes unless they are an integral part of a leg brace;

29. Inpatient treatment for chemical dependency or alcoholism not received in a certified Addiction Rehabilitation Facilities (CARF) or facilities who have been certified by the Joint Commission on Accreditation of Healthcare Organization (JCAHO);

30. Work-related injury or illness; exams or tests required by your employer or for your continued employment;

31. Expenses incurred while in military service or resulting from declared or undeclared war or armed aggression;

32. Any conditions or treatment of corns, calluses, or the trimming of toenails unless at least part of the nail root is removed or for a patient with diabetes;

33. No benefits will be paid for losses which are due to taking part in a riot or civil disturbance, or while committing or attempting to commit a felony;

34. Confinement in a hospital owned or operated by the federal government, except usual, customary and reasonable fees otherwise payable and incurred at a Veteran's Administrative Facility or by a covered

person as an armed services retiree (or such covered person's dependent) for services or supplies unrelated to military service;

35. Dental services or dental supplies, unless specifically provided;

36. Travel expenses, whether or not recommended by a physician, except for travel reimbursement defined in Article II, Section 14, and ambulance services as specifically provided;

37. Charges for physical therapy, occupational therapy or speech therapy visits that are in excess of the number of visits allowed by the Plan;

38. Take home drugs obtained in a hospital or doctor's office. These charges must be submitted under the separate Prescription plan;

39. Hypnosis and hypnotherapy;

40. Alternative housing expenses;

41. Services rendered by a massage therapist;

42. Services which are not considered by the Plan to be durable medical equipment such as air purifiers, hot tubs, waterbeds, exercise equipment, ergonomic chairs, etc., (whether or not prescribed by a physician);

43. Vitamins, nutritional or dietary supplements or over the counter drugs or medications (whether or not prescribed by your physician); and

44. Wigs or hairpieces.

Extension of Medical Benefits

(Does Not Apply to Kaiser Participants)

For Direct Pay Medical Plan employees who are totally disabled upon the date of termination of coverage, a 12 month disability extension of medical coverage only for the disabling condition is available. A signed Extension of Benefits/Medical Coverage option form, which includes a rejection of COBRA coverage, must be submitted when choosing this disability extension.

Medical benefits for the disabling condition will be payable up to the Plan's maximum and no medical expense benefits will be payable for any injury or illness not related to the disabling condition. This extended disability extension shall terminate on the earliest of:

- the date on which the total disability ceases,
- the date upon which the individual granted an extension becomes eligible for coverage under any other group insurance policy or any group medical benefit or service plan,
- the end of the period of 12 months following the date when eligibility terminated, or
- the date on which no funds are available to provide benefits.

For purposes of this disability extension benefit, a total disability is one which prevents the employee from engaging in any gainful employment. By electing this disability extension, COBRA continuation coverage rights are forfeited.

Kaiser plan participants should contact Kaiser directly in terms of disability extension features which may be available under their program.

Usual, Customary and Reasonable Fees (UCR)

Covered charges under the Direct Pay Medical Plan for non-PPO network providers are based on usual, customary and reasonable fees as determined by the Fund in accordance with the following standards:

(1) The Usual fee is that fee regularly charged for a given service by an individual physician to his private patient.

(2) A fee is Customary when it is within the range of usual fees charged by physicians of similar training and experience for the same service within that same specific and limited geographical area or socio-economic area of a community.

(3) A fee is Reasonable when it meets the other two criteria and, if reviewed by a committee of the responsible physician's society, such fee is justifiable by the special circumstances of the particular case in question.

What To Do When You Have A Self-Submitted Claim

Whenever any of the benefits provided under this Plan become payable, and services are not obtained from a provider who direct bills to the PPO network, obtain a claim form from the Fund Office or Teamsters Local Union No. 856. In filing your claim, whether for self or dependent, here are some important things to remember:

1. Fill out and sign your part of the form before forwarding it to your doctor. Make sure you sign the authorization to release medical information as indicated on the form.

2. Attach all bills relating to the claim and be sure they are itemized. Incomplete forms and unclear bills may delay payment.

3. If you are requesting payment be made directly to you, submit proof of payment of the services rendered.

4. Mail the completed form to the Fund Office along with the bills as soon as possible. Direct them to Teamsters Local Union No. 856 Health and Welfare Fund, 1000 Marina Blvd Ste 400, Brisbane, CA 94005-1841.

5. For the purpose of determining the legitimacy and/or necessity of a claim, the Plan may require that medical records or proof of payment be submitted to support the services rendered.

6. Please note that claims must be submitted within 120 days of the day of first treatment for which you are filing a claim. In no event shall benefits be allowed if notice of claim is made beyond one year from the date expenses were incurred.

DIRECT PAY MEDICAL PLAN BENEFITS
Preferred Provider Option (PPO) Plan
(For Medicare Eligible Retirees/Dependents of Retirees)

When you retire and are no longer eligible for benefits as an Active Employee or a non-Medicare Retiree, or if you are the dependent spouse of such a retiree, when you become eligible for Medicare due to age or disability, you must enroll in both Part A and Part B Medicare. Your claims will be paid first by Medicare. Once Medicare has completed their determination on the charges, the claims will be submitted to this Plan by Medicare. If you utilize a provider who does not accept Medicare assignments, or who does not bill Medicare directly, you will need to submit the itemized claim directly to the Trust Office.

If you are age 65 or older you must enroll in Part A and Part B of Medicare to be eligible for benefits from the Direct Pay Plan. An individual who does not automatically qualify for Medicare because of a lack of Medicare-covered employment can buy into Medicare Parts A and B from Medicare. If you do not enroll in Part A and Part B of Medicare, the Plan will pay benefits as if Medicare had paid primary benefits, You will be responsible for your normal out of pocket costs plus all amounts that Medicare would have paid. This same rule applies if you enter into a "Private Contract" with a provider in which you agree that the provider does not submit any of his/her charges to Medicare and you are responsible for the billed charges.

If you do not automatically qualify for Medicare because of insufficient Medicare covered service, you can still enroll in the Kaiser HMO option, however the additional surcharge from Kaiser will added to your monthly share of cost. This does not apply to anyone who retired and enrolled in retiree coverage before July 31, 2020. This also does not apply to any employee who has been continuously employed by the same state or local governmental employer since before April 1, 1986 and did not pay into Medicare, so long as the employer has been making contribution into this plan since January 1, 2015.

There is a $250 annual deductible ($500 per family) that must be satisfied before benefits are payable. Once satisfied, Plan benefits are calculated at 80% of the Plan's Usual, Customary and Reasonable (UCR) fee on eligible billed expenses. Provided the Plan's allowable amount is greater than or equal to the patient balance after Medicare's reimbursement, the patient balance will be reimbursed in full. If the Plan benefit is less than the balance after Medicare's reimbursement, the patient will have an out of pocket amount to pay.

Benefits under the Plan for Medicare eligible Retirees/Dependents will be paid in accordance with standard Coordination of Benefit provisions. Medicare will always be the primary payer and this Plan will pay second. In the event services are not covered by Medicare, but there is a benefit available under this Plan, the Plan will pay up to its maximum allowable. All Plan benefits are subject to the Medical Exclusions listed on pages 67 to 69 of this Plan booklet.

TEAMSTERS ASSISTANCE PROGRAM (TAP)

TAP is a program established to provide assessment and referral for treatment of substance abuse problems. In addition, TAP counselors are available to provide short-term problem focused assessment sessions regarding work, personal, family and marital issues.

Substance Abuse Assistance

TAP counselors will either schedule an appointment for you or your Dependent or direct you to the most appropriate health care professional in their pre-screened network for additional assistance or treatment. TAP counselor(s) advocate on behalf of the participant to help provide the recommended level of care. TAP Counselor(s) monitor the participant's progress while in treatment and provide post-treatment follow-up and referral to TAP's two-year continuing care program. Participants are eligible to participate in TAP's monthly sobriety celebrations, Alumni Association activities and support services.

After you or your Dependent has met the annual medical plan deductible (see page 58) the Plan covers TAP providers as any other PPO provider, and non-TAP providers as any other non-PPO provider.

Employee Assistance

TAP is also a confidential assessment and referral counseling service for you and your Dependents who have concerns or problems that are affecting your work or home life. The program provides help with things like:

- Personal/emotional problems
- Stress-related issues
- Marital/family issues
- Financial problems
- School-related problems your children are experiencing
- An aging parent

Up to three (3) visits are available with a TAP counselor who provides short-term problem focused assessment sessions regarding work, personal, family or marital problems. Should counseling be requested, or determined to be necessary, the participant is referred to the mental health services provided by his medical plan.

How to Contact TAP

Participants who wish information or feel the need to utilize the TAP services available can call (800) 253-8326.

Participants in an HMO Medical Plan

If you are covered under one of the HNO medical plans offered by the Fund, TAP counselor(s) will utilize available substance abuse benefits available from your medical plan.

PRESCRIPTION DRUG BENEFIT

The prescription drug benefits described in this section are available to active Plan participants and their dependents who are enrolled in a Self-Pay Medical Plan. In addition, retired employees and their dependents who are enrolled in the Self-Pay Medical Plan but are not yet eligible for Medicare are also covered under this benefit.

Note: Actives enrolled in Kaiser have prescription drug benefits through their HMO, which is described in a separate brochure. Your prescription drug benefits are determined by your collective bargaining agreement. Some actives enrolled in Kaiser receive prescription drug benefits described below if it is part of your collective bargaining agreement. Retirees in the Self-Pay Medical Plan eligible for Medicare and their dependents eligible for Medicare are covered under the Employer Group Waiver Program through Express Scripts (administered by United American), as described in a separate brochure.

Prescription drug coverage is available in two convenient ways; either through the Retail Pharmacy Card Program or the Mail Order Program. Both programs are administered by OptumRx. You can contact OptumRx directly for information about participating pharmacies, mail-order prescriptions and to order refills:

- The toll free Customer Service number is (800) 797-9791. You can call Customer Service 24 hours a day, 7 days a week.
- The Optum Rx website is ***www.optumrx.com***.

Retail Pharmacy Card Program

The Retail Pharmacy Card Program provides a 100-day supply of medication per prescription or refill at a pharmacy.

This program offers you the convenience of local participating pharmacies for your short-term and immediate prescription drug needs. You can use a participating pharmacy in the OptumRx network or you may purchase your drugs at any pharmacy, the choice is yours each time you need a prescription filled.

Under this program, the following copays apply to most employees:

Type of Prescription Drug	Copay
Generic	$10
Brand-name	$20

Note: You may have a benefit with a $0 copay per prescription or refill, as determined by your collective bargaining agreement.

This is a **mandatory generic** program. Therefore, if you or your doctor requests a brand name drug instead of the generic equivalent, you will be charged the difference in cost between the brand name drug and the generic, in addition to the brand-name drug copay.

When you use an OptumRx network participating pharmacy, you have the advantage of receiving discounted prices and there are no claim forms to file. At participating pharmacies, the pharmacist will use a computerized system to confirm your eligibility for benefits and determine the discounted cost of your prescription. Simply present your prescription card and make your appropriate copay. Your copay depends on whether the prescription is for a generic or brand-name drug.

If you use a non-participating pharmacy, you will have to pay the full cost of the prescription and file a claim with OptumRx to be reimbursed for the cost minus the applicable copay. Claim forms may be obtained from OptumRx or the Fund Office. A claim form must be submitted with copies of the prescription receipt (not cash register receipts) and sent to the address on the form.

Mail Order Program

The Mail Order Program offers you the convenience of receiving at your home up to a 90-day supply of medication per prescription or refill.

The Mail Order Program is designed for maintenance medications for ongoing or chronic conditions. Your copay depends on whether the prescription is for a generic or brand-name drug. The copay amounts are shown in the following table.

Type of Prescription Drug	Copay
Generic	$10
Brand-name	$20

Note: If you are covered by a Maintenance of Benefits (MOB) contract, you may have a benefit with a $0 copay per prescription or refill.

However, if you or your doctor request a brand name drug instead of a generic equivalent, you will be charged the difference in cost between the brand name drug and the generic, in addition to your copay.

How to Use the Mail Order Program

To use the mail order program for the first time, complete a patient profile questionnaire. The questionnaire asks for information about your medical history, blood type, allergies and any other drugs you are taking (prescription and over-the-counter). OptumRx keeps this information and checks it every time you send a prescription. You may update your profile as you like by including any health condition changes with your prescription. Follow these steps:

- Obtain an envelope (from OptumRx, the Fund Office or your Local Union). Complete the information requested on the envelope, including your physician's name. OptumRx automatically fills your prescriptions with a generic alternative whenever possible.
- If you are getting a new prescription filled, have your physician prescribe up to a 90-day supply of the maintenance drug with the appropriate number of refills. If your physician specifies a brand-name drug and writes "Dispense as Written" (DAW) on the prescription, the pharmacist will fill your prescription with the brand-name drug rather than filling it with a generic drug. However, the pharmacist may call your physician to request approval of filling your prescription with a generic drug.
- If you are requesting a refill, you should request your refill at least two weeks before your prescription runs out. With each prescription, OptumRx sends a postage-paid envelope (for your future use) and a notice showing how many refills you have left. Be sure to contact your physician when you request your last refill from OptumRx.
- Send your prescription (and questionnaire if it's your first order) or request for a refill and the appropriate copayment in the postage-paid envelope to OptumRx. You can pay by check, money order, MasterCard or Visa. If use a credit card, include the card number and expiration date. DO NOT SEND CASH.

Within three weeks after ordering a new prescription or two weeks on a refill, your prescription will arrive, at the address you indicated on the envelope, by United Parcel Service (UPS) or U.S. Mail.

If you have any questions or need assistance with the mail order program, contact OptumRx at (888) 290-9990.

Preventive Care Prescription Drugs

In accordance with Federal law, the Plan covers preventive care drugs at 100% with no copay when purchased at an OptumRx network participating pharmacy. Preventive care drugs may include aspirin, tobacco cessation drugs, contraceptive drugs and devices, vitamin and mineral supplements as well as other products. Gender, age and/or other limits apply. Please note that over the counter (OTC) drugs require a prescription to be covered and quantity limits may apply to some drugs.

A complete and up-to-date list of preventive care drugs can be found at ***www.hhs.gov/healthcare***. This list may be subject to change.

Vaccination Program

All vaccations required by the Affordable Care Act.

Briova Rx Specialty Pharmacy

Some specialty oral and injectable medications, such as those used to treat Hepatitis C, Multiple Sclerosis, and Cancer, must be filled by BriovaRx Specialty Pharmacy. This program not only supplies the prescribed medication and related supplies, such as needles and syringes, but also provides clinical support to you to help improve compliance as well as provide convenient delivery. If you are currently being prescribed a medication that can be filled as part of this program, you will receive more information under separate cover.

To begin using BriovaRx Pharmacy, you or your physician can call (877) 342-4596.

Prior Authorization

Under Prior Authorization, prescriptions for certain medications require coverage review before the Plan will cover the medication. If your doctor prescribes one of these medications, your pharmacist or your doctor must call the OptumRx prior authorization department at (800) 711-4555 Option #1 or submit the information through the online provider portal at optumrx.com. OptumRx will work with your doctor(s) office to get the information for the coverage review. If your doctor does not return the information we ask for, the Prior Authorization request will be denied. OptumRx will notify you and your doctor if the request is denied.

The benefits of Prior Authorization include:

- Promoting safe and effective use of medications
- Helping manage expensive and/or highly used drug categories.

Here are some examples of drug classes that require a prior authorization. This is not a complete list; Blood Formation Agents, Growth Hormone, Hepatitis C, Psoriasis, Pulmonary Hypertension, Rheumatoid Arthritis, Testosterone Replacement, Sleep Disorder, Weight Loss and select pain medications. Some medications may require prior authorization based on age or quantity limits.

Once we review the information from your doctor, we will send a letter to you and your doctor letting you know if your medication coverage is approved or denied.

- If your medication is **approved**, the prior authorization is entered and coverage will be provided under your benefit. You can continue to fill your prescription at the pharmacy as usual during the approved prior authorization period. Depending on your benefit plan and medication, you may be able to save money by using the OptumRx Mail Service Pharmacy.

- If your medication is **denied**, the letter you receive will explain the reason for the decision and provide information about the appeal process.

Orphan Drug Program

Optimize care of orphan drugs where clinical evidence shows a limited response and considerable intolerability rates, complicated dosing and significant adverse events, multiple opportunities for pharmacist to optimize care.

Vigilant Drug Program
This program helps to ensure clinically appropriate medications by removing certain medications from coverage. It includes the Vigilant High Cost Generics program.

Variable Copay Solution
Maximization of copay card value.

Covered Drugs
The prescription Drug Program covers prescription drugs and medicines when prescribed by a physician or other lawful prescriber. This includes:

- All drugs which must be dispensed under federal or state law upon the written prescription.
- Diabetic supplies (if prescribed). Covered diabetic items include:
  - Insulin vials
  - Insulin syringes and needles
  - Insulin pre-filled pen with insulin and needle (disposable)
  - Insulin cartridges
  - Penneedles
  - Blood glucose test strips
  - Urine glucose test strips
  - Lancets

  The following diabetic supplies are excluded:
  - Insulin pen device
  - Lancet devices
  - Blood glucose monitors
  - Blood glucose monitor supplies

Prescription Drug Program Exceptions and Exclusions

1. Drugs or medication procured or procurable, except as noted above, without a Doctor's written prescription.
2. Immunization agents.
3. Drugs necessary for illness or injury covered by any workers' compensation or occupational disease law, or any state or government agency.
4. Drugs to be taken or administered to the eligible member while he/she is a patient in a hospital, nursing home, rest home, sanitarium etc.
5. Drugs that are experimental, or investigational.
6. Drugs that do not have the full approval of the U.S. Food and Drug Administration (FDA) or the manufacturer for the condition for which they have been prescribed.
7. Appetite suppressants or weight loss agents.
8. Drugs for which no charge is made.
9. Drugs that are lost or stolen.

10. Cosmetic, health or beauty aids.

11. Fertility drugs.

12. Drugs furnished by any other drug or medical service for which no charge is made to the patient.

13. Certain prescription drugs require prior authorization to determine if it will be covered under the pharmacy benefit. If OptumRx determines that a prescription drug requiring a preauthorization is not approved or effective for treating specific conditions, cost more than other medications used to treat the same or similar conditions, or prescribed for conditions for which their safety and effectiveness have not been proven, OptumRx will deny prior authorization for the medication. You or your physician can determine which medication requires prior authorization by logging in online at optumrx.com and entering the drug name and dose. You or your physician may also contact the OptumRx Customer Service Center using the phone number on the back of your ID card. If your medication needs prior authorization, your prescribing physician can submit a prior authorization form through the online portal at optumrx.com. OptumRx will send you and your doctor a letter letting you know if your medication is approved or denied. If your medication is denied, the letter you receive will explain the reason for the decision and provide information about the appeal process.

VISION BENEFITS

Your vision benefits are determined by your collective bargaining agreement.

Vision Service Plan (VSP) Network

The Board of Trustees has contracted with Vision Service Plan (VSP) for the purpose of making their expansive network of preferred providers available to employees and their eligible dependents. When you use a VSP provider you will pay less than if you use a non-preferred provider. Log in to vsp.com to check your benefits for eligibility and to confirm in-network locations based on your plan type.

Annual WellVision Exam

You are eligible for a WellVision Exam once every 12 months at a $15 copayment. Some collective bargaining agreements allow for an exam at no cost to you.

Prescription Glasses

If you obtain services and supplies from a VSP provider, you will have a $150 allowance for frames ($170 for some featured frame brands; $80 from Costco). Frames are covered once every 24 months.

Prescription Lenses

Single vision, lined bifocal, lined trifocal, and standard progressive lenses are available at no cost to you once every 12 months. Enhancements such as premium or custom progressive lenses are available at a copayment.

Contact Lenses

In lieu of prescription glasses, you will have up to a $130 allowance for contact lenses every 12 months.

LIFE AND ACCIDENTAL DEATH & DISMEMBERMENT BENEFITS

This section summarizes the Fund's Life and Accidental Death and Dismemberment benefits underwritten by The Standard Life Insurance Company. In the event of any inconsistencies between this summary and the actual provision of the Group Life Insurance Certificate, the actual provision of the Certificate shall prevail.

Note: These benefits are not available to Retirees and their Dependents.

Life Insurance

The Life Insurance benefit is the amount of life insurance payable to your beneficiary upon your death. In the case of the death of your spouse, your Domestic Partner or dependent child, it is the amount of life insurance payable to you.

Benefit

The Plan will pay the maximum amount as listed below. This amount is determined by the contribution amount paid by the participant's employer established through the collective bargaining process. Contact your employer or the Fund Office to determine your amount of coverage.

INSURANCE AMOUNT

EMPLOYEE	**DEPENDENT**
$50,000	$500 – Spouse/Domestic Partner
	$500 – Child

Dependent children are covered from birth through age 26. Mentally or permanently physically handicapped children are eligible for the Life Insurance benefit after their 26th birthday. Children of a Spouse (i.e., Domestic Partner) are eligible for the Life Insurance benefit if living in your home.

The proceeds may be paid on a monthly basis for a fixed term or years:

1. If the insured sends us his written request;
2. If the Fund agrees in writing.

Designation of Beneficiary

You, the participant, are automatically the beneficiary of the Life Insurance benefit for your spouse or Domestic Partner, and dependent children. No one else may be named as beneficiary.

In the case of your death, your named beneficiary, or beneficiaries, will receive the Life Insurance benefit and/or Accidental Death benefit amount(s). You, the participant, may name anyone that you want as your beneficiary. It is extremely important that you name someone.

A person becomes beneficiary only if you have named that person as your beneficiary on your Enrollment Card. You may change your beneficiary at any time by filling out a Change of Beneficiary form which is available through the Fund Office. A completed form indicating your named beneficiary must be on file with Fund to avoid disputes regarding your proper beneficiary.

If you do not designate a beneficiary, or your beneficiary is no longer living, payment will be made as stated in the Certificate.

Total and Permanent Disability Benefit (Active Employees Only)

If you become totally and permanently disabled before your 70th birthday while you are a covered employee, your Life Insurance will remain in force (with payment of premium) during the disability.

The term total disability, as used herein, means that, as a result of sickness, accidental injury, or pregnancy, you are unable to perform with reasonable continuity the material duties of any gainful occupation for which you are reasonably fitted by education, training and experience.

If you become totally disabled, your Life Insurance will not end, but will be extended provided:

(a) The disability began while you were insured under this provision;

(b) The disability began before you reached age 70;

(c) The policy does not end; and,

(d) Proof of the disability is submitted as described in the following paragraph.

You should send the Fund Office notice of your total disability not later than the ninth through the twelfth month of disability. The Fund Office will then send you the initial proof form for you and your physician to complete. Upon receipt and acceptance of initial proof, the Fund Office will extend your insurance for a period of one year. Thereafter you and your physician must submit yearly proof that you are totally disabled. The proof must be submitted during the three-month period before each anniversary of receipt of initial proof. If proof is acceptable, insurance will be extended for further terms of one year. However, insurance will not be extended beyond the date you are no longer totally disabled.

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

(a) Your death was within 12 months from the day insurance would have otherwise ended; and,

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

Your extended insurance is the amount in force on the day insurance would have otherwise ended.

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

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

If a conversion policy has been issued to you, we will pay benefits under this extended provision only if the conversion policy is returned to us without claim. We will refund all paid conversion premiums if your conversion policy is surrendered for this reason.

Conversion Privileges

If any of your Life Insurance ends because your employment or membership in a class ends, you may apply for an individual policy of life insurance (called a conversion policy) without giving information about your health. Issuance of a conversion policy is subject to the following conditions:

(a) You may apply for any of the life insurance company's individual life insurance policies except term insurance. You may not apply for any supplemental coverage.

(b) You may apply for an amount which is not more than the amount of your terminated group life insurance.

(c) The premium for your conversion policy will be at the life insurance company's standard rate for that type of policy according to:

(1) Your class of risk; and,

(2) Your age on the date the policy takes effect.

(d) You must submit your written application and your first conversion premium to the life insurance company within 31 days after your group life insurance ends or reduces.

If your group life insurance ends because of termination of the policy or termination of a class, and you have been insured under the policy at least five years, you may apply within 31 days for a conversion policy. Issuance of the conversion policy is subject to conditions (a), (c) and (d) above. Your converted life insurance may not exceed the lesser of:

(a) $3,000.00; or,

(b) The amount of your terminated group life insurance less the amount of any other group life insurance for which you become eligible within 31 days.

If you die within the 31-day period after insurance ends, the Fund will pay the amount of group life insurance you were entitled to convert.

If the life insurance company issues a conversion policy and you again become eligible for group life insurance under the policy, coverage will become effective only if:

(a) You terminate the conversion policy; or,

(b) You submit, at your own expense, evidence of good health acceptable to the Fund Office.

Accidental Death & Dismemberment (Active Employees Only)

If, because of an accident you have while you are covered by the Plan, you suffer any of the losses listed below within 90 days of the accident, the maximum benefit amount listed will be paid to you or your beneficiary.

Accidental Death

The benefit for Accidental Death is payable in addition to the Life Insurance benefit for covered participants. The Accidental Death Benefit will be paid to your beneficiary. The Fund reserves the right to have an autopsy conducted in connection with a claim for accidental death.

Accidental Dismemberment

All benefits for Accidental Dismemberment or loss of sight will be paid to you immediately after the Fund receives satisfactory proof of loss. A dismemberment loss with regard to hands or feet means severance at or above the wrist or ankle joints respectively. A loss with regard to the eyes means total and irrecoverable loss of sight. The Fund has the right to require a medical examination in connection with a claim for accidental dismemberment.

Benefit

The Plan will pay the maximum amount listed in the following schedule.

Loss of:	Maximum Payable	Paid To
Life	Principal Sum	Your Beneficiary
Both hands or both feet or sight of both eyes	Principal Sum	You
Any combination of foot, hand, or sight of one eye	Principal Sum	You
On hand, one foot or sight of one eye	50% of the Principal Sum	You

A maximum benefit amount of the Principal Sum is payable for all losses resulting from one accident.

Exclusions

The Accidental Death and Dismemberment benefit does not cover losses caused by the following:

1. Intentional self-inflicted injury — or any attempt to injure oneself while sane or insane; or,
2. Taking part in a riot; or,
3. Any war or act of war — declared or undeclared; or,
4. Military service; or,
5. Taking part in an assault or a felony; or,
6. Voluntary use of any controlled substance (as defined in Title II of the Comprehensive Drug Abuse Prevention Control Act of 1970). This exclusion will not apply if the controlled substance is prescribed for the insured by a physician; or,
7. Sickness or Pregnancy existing at the time of the accident;
8. Heart attack or stroke;
9. Medical or surgical treatment for any of the above.

Claim Filing

File claims for the Life Insurance and other benefits through the Fund Office.

All claims should be filed as soon as possible. Life Insurance, and Accidental Death and Dismemberment claims must be filed within one year of the date of loss.

Total and permanent disability waiver of premium claims must be filed within 1 year of the date that your Plan coverage has ended.

Claims for Life Insurance and Accidental Death benefits must be filed with the Fund Office together with a certified copy of the Death Certificate.

1. Life Insurance and Accidental Death Claims for Participant Death or Accidental Death

The beneficiary of the Participant should send a certified copy of the Death Certificate to the Fund Office with a completed claim form.

For Death of Dependent Spouse

Send a certified copy of your Marriage Certificate and a certified copy of the Death Certificate to the Fund Office.

For Death of a Dependent Domestic Partner

Send a copy of your Domestic Partner enrollment form, a notarized Affidavit of Domestic Partnership and a certified copy of the Death Certificate to the Fund Office.

For Death of a Dependent Child

Send a certified copy of the Birth Certificate and a certified copy of the Death Certificate to the Fund Office. Additional proof of dependency may be required.

2. Accidental Dismemberment Claims (Employee Only)

File claims for Accidental Dismemberment Benefits with the Fund Office as soon as possible from the date of dismemberment.

FUND MANAGER:

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