IBEW LOCAL 234

HEALTH AND WELFARE PLAN

SUMMARY PLAN DESCRIPTION

(Medical, Prescription Drugs, Vision, Dental, Death and Accidental Death and Dismemberment Benefits)

[ANTHEM BLUECROSS PRUDENT BUYER PPO NETWORK]

JANUARY 2023

KEEP THIS BOOKLET FOR FUTURE REFERENCE

BOARD OF TRUSTEES

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BENEFIT CONSULTANT	**AUDITOR**
Rael & Letson	Miller Kaplan Arase & Co. LLP

BENEFIT CONTACT INFORMATION

NETWORK/COST CONTAINMENT
ANTHEM BLUECROSS (Group Number: 277790M001) (800) 274-7767 (including pre-authorizations) A provider search can be performed at www.anthem.com/ca
VISION BENEFITS (Group Number: 30052226) **VSP Provider Network: VSP Choice** VSP: (800) 877-7195 (800) 428-4833 (toll-free TTY for hearing/speech impaired) www.vsp.com
DENTAL (Group Number: 345) DELTA DENTAL: (800) 765-6003 deltadentalins.com
PRESCRIPTION DRUGS (Group Number: IBEW234) Sav-Rx: (800) 228-3108

IBEW LOCAL 234 HEALTH AND WELFARE PLAN

1731 Technology Drive, Suite 570
San Jose, California 95110
(877) 885-3753 Toll-Free
(408) 588-3753
www.IBEW234benefits.org

Dear Participant:

This booklet is both the Restated Plan document and Summary Plan Description for the IBEW Local 234 Health and Welfare Plan, except for the life insurance and accidental death and dismemberment benefit, which are provided through an insurance company. This booklet contains information regarding your medical and related benefits and an explanation of the eligibility provisions for both active and retired Participants. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Plan Office at the above address or at (877) 885-3753. Information and forms are available on the Plan's employee benefit website: www.IBEW234benefits.org. Anthem Blue Cross, which is the Network Provider for the Plan, can be reached toll-free at (800) 688-3828.

Only the full Board of Trustees is authorized to interpret the Plan. The Board has the discretionary authority to decide all questions about the Plan, including questions about your eligibility for benefits, the amount of any benefits payable to you, and the interpretation of the Plan. No individual Trustee, Employer, or union representative has authority to interpret this Plan on behalf of the Board or to act as an agent of the Board. The Board also has the discretion to make any factual determinations concerning your claim.

As a courtesy to you, the Plan Office may respond informally to oral questions; **however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits.**

Plan rules and benefits may change from time to time. Your benefits under the Plan are not vested. The Board of Trustees may change (including reduce) or eliminate any benefits provided under the Plan (or any insurance policy, HMO, or other entity) at any time. Participants may also be required to make new or additional contributions and/or co-payments or other payments for benefits provided by the Plan.

You may contact the Trust Fund Office at (408) 588-3753 if you have questions.

Board of Trustees

IMPORTANT NOTICES

CAUTION - FUTURE PLAN AMENDMENTS

Future amendments to the Plan may have to be made from time to time to comply with new laws or amendments passed by Congress, rulings by federal agencies or courts, and other changes deemed necessary or prudent by the Board of Trustees. You will be notified if there are important amendments to the Plan. Before you decide to retire, you may want to contact the Trust Fund Office to determine if there have been Plan amendments or other developments that may affect your retirement Plans.

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENT

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to determine your rights fully.

You are not entitled to rely upon oral statements of Employees of the Trust Fund Office, a Trustee, an Employer, Union officer, or any other person or entity. As a courtesy to you, the Trust Fund Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits.

If you wish an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Trust Fund Office. **The Trustees must be furnished with full and accurate information concerning your situation to make their decision.**

You should further understand that, from time to time, there may be an error in a payment or on other matters which may be corrected upon an audit or review. **The Board of Trustees reserves the right to make corrections whenever any error is discovered.**

NO VESTED RIGHTS

Benefits under this Plan are NOT vested. The Board of Trustees may amend or otherwise change the Plan at any time, including the eligibility requirements and any other rules. Moreover, the Board of Trustees may require new or greater co-payments at any time.

NO GUARANTEE OF A PARTICULAR PROVIDER

The continued participation of any one physician, hospital or other provider(s) cannot be guaranteed. The fact that a physician or provider may perform, prescribe, order, recommend or approve a service, supply, or hospitalization does not, in itself, make it medically necessary or guarantee that it is a covered service.

ONE YEAR TO FILE A LAWSUIT/LAWSUITS IN NORTHERN CALIFORNIA/NO CLASS ACTIONS

If a claim has been denied and you filed an appeal which is also denied, or you have a different type of adverse determination, you have one year from the date of the denial of the appeal or the adverse determination to file a lawsuit seeking to overturn the appeal and/or adverse determination. Failure to do so means that you will not be able to file your lawsuit. In addition, any lawsuit for benefits, breach of fiduciary duty or for any other reason must be filed in federal district court in the Northern District of California. Participants beneficiaries and other persons or entities are not permitted to participate in Class Action lawsuits against the Plan or the Trustees.

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PATIENT PROTECTION AND AFFORDABLE CARE ACT (KNOWN AS THE "ACA")

A. Grandfathered Plan

The Board of Trustees believes this Plan is a "grandfathered health plan" under the federal law known as the Patient Protection and Affordable Care Act of 2010 ("ACA"). As permitted by the ACA, a grandfathered health plan can preserve certain basic health coverage that was already in effect when the ACA was enacted. Being a grandfathered health plan means that the Plan is not required to include certain consumer protections of the ACA that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing, although the Board of Trustees adopted preventive health services without cost sharing in 2011. Grandfathered health plans must comply, however, with certain other consumer protections in the ACA, such as the elimination of annual and lifetime limits on the Plan's Essential Health Benefits. (For a definition of what constitutes as Essential Health Benefits please visit *www.Healthcare.gov/glossary/essential-health-benefits).*

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Manager at the number listed on page i. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at (866) 444-3272 or *www.dol.gov/ebsa/healthreform*. This website has a table summarizing which protections do and do not apply to grandfathered health plans. Implementation of the ACA's provisions began with the July 1, 2011, Plan Year.

B. No Pre-Existing Condition Exclusions for Any Individual

The ACA prohibits Plans from imposing pre-existing condition exclusions on any individual. This ban includes both benefit limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual's pre-existing medical condition).

C. Dependent Child Coverage Through Age 25

In accordance with the ACA, the Plan will permit a Participant's eligible child(ren) to be enrolled and maintained as a Dependent through the end of the month in which the child(ren) attains age 26, regardless of whether the child(ren) are eligible for coverage through his or her own employer-sponsored group health plan (or his or her spouse's plan) and regardless of the child(ren)'s marital status, student status, financial dependency, residency, or employment status.

D. Individual Mandate & Minimum Essential Coverage

With certain exceptions, the ACA requires you and your Dependents to have health coverage that qualifies as minimum essential coverage or pay a penalty for noncompliance. Minimum essential coverage includes jointly-sponsored coverage such as this Plan. The ACA also establishes a minimum value standard of benefits for health plans. Minimum value means coverage under a health plan (such as this Plan) meets the minimum value standard if the plan's share of the total allowed costs of benefits provided is 60% or greater. If you are covered under the Plan, you meet the individual mandate. The Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

E. Availability of Summary of Benefits and Coverage

The ACA requires Plans to provide a Summary of Benefits and Coverage, also known as the "SBC", to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, a summary of what the Plan covers and what it costs. It is intended to help you understand and compare the different benefits and coverage options available to you under the Plan. Under the ACA, you have a right to request and receive within 7 business days a copy of the Plan's SBC in paper form, at any time and free of charge.

F. Elimination of Lifetime and Annual Limits on Essential Health Benefits

The ACA prohibits both grandfathered and non-grandfathered health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. The Plan does, however, impose annual limits on certain non-Essential Health Benefits as provided in this document.

SCHEDULE OF BENEFITS
Effective January 1, 2022

This booklet is the Summary Plan Description ("SPD"), which is considered the Plan Document as of January 1, 2022. (There is no separate Plan document.) The first part of the booklet includes a short summary of the Plan's key provisions. The Eligibility Rules and Benefit Rules follow. Exclusions start on page 79.

MEDICALLY NECESSARY REQUIREMENT. Benefits are provided only if determined to be Medically Necessary as defined on page 56 of this booklet. The fact that a physician or other provider may prescribe, order, recommend, or approve a service, supply or hospitalization does not, in itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion or limitation. The Board of Trustees reserves the right to review all claims to determine if a service, supply or hospitalization is medically necessary.

ALERT: REMEMBER THAT THE PLAN MAY NOT PAY YOUR BENEFITS IN DIFFERENT SITUATIONS, SUCH AS A-C BELOW.. See also Article XIV on page 113 for other situations in which benefits may not be paid or there may be a delay in the payment of benefits.

A. **Subrogation/Third Party Claims.** The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible. The Plan may recover any amount it pays for claims from which a Covered Individual received payment under a court judgment, settlement agreement, insurance payment or any other form of payments from a third party, including any payment received from an insurance company.

B. **Coordination of Benefits with Other Plans.** If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims. The Plan sets forth the order and procedures for determining which Plan pays first.

C. **Work-Related Injuries.** The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This is so even though you have not filed a claim with workers compensation.

BENEFIT SCHEDULE

Preventive care benefits are listed in Section 6.36 beginning on page 70.

	NETWORK PROVIDERS	NON-NETWORK PROVIDERS
Annual Deductible Applies to all expenses unless noted. **Note: Does not include co-payments.**	**MEDICAL DEDUCTIBLE AMOUNT** You pay $100 per person per calendar year.	
Maximum Out-Of-Pocket (Your Own Money)	$8,550 Single $17,100 Family (excluding Co-Payments)	
No Medical Lifetime Maximum	**THERE IS NO OVERALL ANNUAL OR LIFETIME MAXIMUM FOR COVERED BENEFITS.**	

MEDICAL BENEFITS		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
BENEFIT	**THE PLAN PAYS**	**THE PLAN PAYS**
Hospital Benefits	(Calendar Year Deductible Applies)	
Inpatient Services	80%, at semi-private room rate.	80% of Network Allowance, patient pays the excess.
Intensive Care Unit	80% up to 300% of semi-private room rate.	80% of Network Allowance, patient pays the excess.
Convalescent Hospital	$20 per day plus 50% of semi-private room rate up to 365 days.	80% of Network Allowance, patient pays the excess.
Extras	80%, except payment not to exceed $50 for physiotherapy in a convalescent hospital during a continuous period of disability.	80% of Network Allowance, patient pays the excess.
Emergency Room	80% after $100 deductible. Deductible waived if admitted.	80% of Network Allowance, patient pays the excess.
Outpatient Services	80% of Network Allowance.	80% of Network Allowance, patient pays the excess.
Ambulance (Deductible Applies)	80% for a surface ambulance. Air ambulance subject to medical review.	Same as in-network.
Physician Services	(Calendar Year Deductible Applies)	
Surgery	80% of Network Allowance.	80% of Network Allowance, patient pays the excess.
Anesthesia	80% of Network Allowance.	80% of Network Allowance, patient pays the excess.
Hospital Visits	80% of Network Allowance	80% of Network Allowance, patient pays excess + co-pay.
Office Visits	80% of Network Allowance, after $25 co-pay.	80% of Network Allowance, patient pays excess + co-pay.
Home Visits	80% of Network Allowance, after $25 co-pay.	80% of Network Allowance, patient pays the excess.
Radiotherapy	80% of Network Allowance.	80% of Network Allowance, patient pays the excess.
Speech Therapy	80% of Network Allowance.	80% of Network Allowance, patient pays the excess.
Chemotherapy	80% of Network Allowance.	80% of Network Allowance, patient pays the excess.
Injectable Medication	80% of Network Allowance.	80% of Network Allowance, patient pays the excess.
Referred Specialist	80% of Network Allowance, 1st $25 co-pay waived.	80% of Network Allowance, 1st $25 co-pay waived, patient pays excess.
Physical therapy	80% of Network Allowance, 20 visits maximum per calendar year	Same - patient pays excess.

MEDICAL BENEFITS		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
BENEFIT	**THE PLAN PAYS**	**THE PLAN PAYS**
Diagnostic Coverage	(Calendar Year Deductible Applies)	
X-ray Procedures	80% of Network Allowance.	Same - patient pays excess over Network Allowance.
Laboratory Procedures	80% of Network Allowance.	Same - patient pays excess over Network Allowance.
Mental Health Care	(Calendar Year Deductible Applies)	
Inpatient	Same basis as benefit provided for any other illness.	Same - patient pays excess over Network Allowance.
Outpatient	80% of Network Allowance not to exceed.	Same - patient pays excess over Network Allowance.
Chiropractic Benefit	(Calendar Year Deductible Applies)	
Coverage	80% of Network Allowance after $25 co-pay. 12 visits maximum per calendar year.	Same - patient pays the excess over Network Allowance and the 12 visits per calendar year.
Maternity Benefits	(Calendar Year Deductible Applies)	
Coverage (For employee or spouse only)	Treatment of pregnancy shall be on the same basis as the treatment for any illness. A hospital length of stay is allowed for the mother and newborn child for up to 48 hours following a vaginal delivery and up to 96 hours following a cesarean section delivery. No authorization is required for a hospital length of stay that does not exceed these periods. Benefits for a shorter period will apply if the patient's attending provider, after consultation with the mother, has approved an earlier discharge.	
Temporal Mandibular Joint (TMJ) Benefit	(Calendar Year Deductible Applies)	
Coverage	80% of Network Allowance. Maximum $1,000 lifetime benefit.	Same - patient pays excess over Network Allowance. Maximum $1,000 lifetime benefit.
Substance Abuse Benefit	(Calendar Year Deductible Applies)	
Coverage	80% of Network Allowance.	Same – 80% of Network Allowance, patient pays the excess..
Acupuncture Benefit	(Calendar Year Deductible Applies)	
Coverage	80% treatment by a physician or acupuncturist licensed by the State. Benefits payable: initial visit, per condition, not to exceed $60. Additional visits not to exceed $30. Maximum calendar year visits (for all conditions) not to exceed 10.	Same
Home Health Care Benefit	(Calendar Year Deductible Applies)	
Coverage	80%, maximum visits 100 per calendar year. Maximum benefit per visit is $35, nutritional counseling maximum benefit is $50 per calendar year.	Same - patient pays excess over Network Allowance. Maximum visits 100 per calendar year.
Hospice Care Benefit	(Calendar Year Deductible Applies)	
Coverage	80% of Network Allowance	Same

MEDICAL BENEFITS		
	NETWORK PROVIDERS	**NON-NETWORK PROVIDERS**
BENEFIT	**THE PLAN PAYS**	**THE PLAN PAYS**
Additional Accident Benefit	(Calendar Year Deductible **DOES NOT** Apply)	
Coverage	80% of Network Allowance, for charges incurred within 90 days of accident.	Same - patient pays excess over Network Allowance.
Well Child Care Benefit	(Calendar Year Deductible Applies)	
Coverage		
1. The charge of an acute care hospital for routine nursery care furnished to a newborn well baby while the mother is an inpatient.	100% of Network Allowance.	Same - patient pays excess over Network Allowance.
2. The charge of a physician for the initial pediatric examination of a newborn performed before the child is released from nursery care.	100% of Network Allowance.	Same - patient pays excess over Network Allowance.
3. The charges of a physician for no more than 15 outpatient visits through the age of 5 years.	100% of Network Allowance after applicable $25.00 co-pay.	Same - patient pays excess over Network Allowance.
Well Adult Care Benefit	(Calendar Year Deductible Applies)	
Coverage		
1. Females Age 18 and older, one annual cervical cancer screening examination, including PAP smear, a breast examination and for age 40 and older a mammogram, as recommended by the American Cancer Society.	80% of Network Allowance	Same - patient pays excess over Network Allowance.
2. Males Prostate cancer screening, PSA blood test, and digital rectal examination, as recommended by a physician.	80% of Network Allowance	Same - patient pays excess over Network Allowance.

PRESCRIPTION DRUG BENEFITS	
Retail[1] (up to a 30-day supply)	Generic: 20% Preferred Brand: 20% Non-Preferred Brand: 30%
Mail Order (up to a 90-day supply)	Generic: $10 Brand: $20

[1] Plus $10 for each prescription or refill at a retail pharmacy.

VISION BENEFITS
YOUR COVERAGE WITH A VSP PROVIDER

Vision Care Benefit (VSP) - To find a VSP provider, visit www.vsp.com or call (800) 877-7195

BENEFIT	DESCRIPTION	COPAY
WellVision Exam	Focuses on your eyes and overall wellness Every calendar year	$15
Prescription Glasses		$25
Frame	$150 allowance for a wide selection of frames $170 allowance for featured frame brands 20% savings on the amount over your allowance Every other calendar year	Included in Prescription Glasses
Lenses	Single vision, lined bifocal and lined trifocal lenses Polycarbonate lenses for dependent children Every calendar year	Included in Prescription Glasses
Lens Enhancements	Standard progressive lenses Premium progressive lenses Custom progressive lenses Average savings of 20-25% on other lens enhancements Every calendar year	$55 $95-$105 $150-$175
Contacts (instead of Glasses)	$150 allowance for contacts; copay does not apply Contact lens exam (fitting and evaluation) Every calendar year	Up to $60
Additional Coverage	Diabetic Eye care Plus Program	
Extra Savings	**Glasses and Sunglasses** Extra $20 to spend on featured frame brands. Go to vsp.com/special offers for details. 20% savings on additional glasses and sunglasses, including lens enhancements, from any VSP provider within 12 months of your last WellVision Exam. **Laser Vision Correction** Average 15% off the regular price or 5% off the promotional price; discounts only available from contracted facilities	

Your Coverage with Out-of-Network Providers

Visit vsp.com for details if you plan to see a provider other than a VSP network provider.

Exam	up to $45	Lined Trifocal Lenses	up to $65
Frame	up to $70	Progressive Lenses	up to $50
Single Vision Lenses	up to $30	Contacts	up to $105
Lined Bifocal Lenses	up to $50		

DENTAL BENEFITS		
Delta Dental (Delta Dental - Group Number: 345)		
ELIGIBILITY	Primary enrollee, spouse and eligible dependent children to the end of the month dependent turns age 26	
Deductibles Deductibles waived for Diagnostic & Preventive (D & P)	$25 per person each calendar year	
	No	
MAXIMUMS	Delta Dental PPO dentists: $2,500 per person each calendar year Non-Delta Dental PPO dentists: $2,000 per person each calendar year	
WAITING PERIOD(S)	Basic Benefits: None Major Benefits: None Prosthodontics: None	
BENEFITS AND COVERED SERVICES[1]	**Delta Dental PPO Dentists[1]**	**Non-Delta Dental PPO Dentists[2]**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	90%	80%
Basic Services Fillings, simple tooth extractions and sealants	80%	80%
Endodontic (root canals) Covered Under Basic Services	80%	80%
Periodontics (gum treatment) Covered Under Basic Services	80%	80%
Oral Surgery Covered Under Basic Services	80%	80%
Major Services Covered Under Basic Services	80%	80%
Prosthodontics Bridges, dentures and implants	80%	80%

Delta Dental of California
100 First Street
San Francisco, CA 94105

Customer Service
(800) 765-6003

Claims Address
P.O. Box 997330
Sacramento, CA 95899-7330

1 Limitations or waiting periods may apply for some benefits; some services may be excluded from your plan. Reimbursement is based on Delta Dental maximum contract allowances and not necessarily each dentist's submitted fees.

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

LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFITS

To file a claim for death benefits or Accidental Death or Dismemberment Insurance, call the Trust Fund Office at (408) 588-3753 or (877) 885-3753. Life insurance benefits are not subject to COBRA.

A. DEATH BENEFITS: $50,000 for Active Employees/$15,000 for Retired Participants

The Plan self-funds the death benefits that are payable from the Plan. Upon the death of an active Participant on or after January 1, 2018, the Plan will pay $50,000 in death benefits. Upon the death of a retired Participant on or after January 1, 2018, the Plan will pay $15,000 in death benefits.

B. BENEFICIARY

Your beneficiary may be any person or persons you name. You may change your beneficiary at any time by making a written request upon a form available at the Trust Fund Office. A change of beneficiary form must be received by the Trust Fund Office before your death to be effective. If you do not name a beneficiary, benefits will be paid to your surviving spouse and if none, in equal shares to your natural or legally adopted children. If you have no children, benefits would be paid to your estate.

C. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Plan self-funds the accidental death and dismemberment benefits that are payable to Active Participants of the Plan.

An additional benefit will be paid for any of the following losses occurring on or off the job through purely accidental means, if the loss occurs while the insurance was in force, within 365 days after the injury, and due to an injury independent of all other causes.

For Participants under age 65, the full amount of the Accidental Death and Dismemberment benefit, which is $50,000, will be paid for the loss of:

Life	Quadriplegia
Both hands and both feet	One hand and sight of one eye
One foot and sight of one eye	

One-half of the amount of your Accidental Death and Dismemberment benefit or $25,000 will be paid for the loss of one hand, one foot or the sight of one eye.

Paraplegia	Hemiplegia
Loss of one hand	Loss of one foot
Loss of sight in one eye	Loss of speech
Loss of hearing	

Loss of sight means total and irrecoverable loss of sight. Loss of hands or feet means severance at or above the wrist or ankle. Loss of speech means the total and irrecoverable loss of speech. Loss of hearing means total and irrecoverable loss of hearing. Quadriplegia means total and permanent Paralysis of both upper and lower limbs. Paraplegia means total and permanent Paralysis of both lower limbs. Hemiplegia means total and permanent Paralysis of upper and lower limbs on one side of the body. Paralysis means permanent impairment and loss of the ability to voluntarily move or to have sensation in any entire extremity. Paralysis must be the result of an injury to the brain or spinal cord and without the severance of a limb.

For active Participants age 65 through 69 the accidental death benefit is $25,000. For Participants age 70 and above, the accidental death benefit is $12,500.

The death benefit is payable to your beneficiary. The dismemberment or loss of sight benefit is payable to you in the manner described above in the life insurance section.

D. LIMITATIONS/EXCLUSIONS (TO THE LIFE INSURANCE AND ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT)

Payment for all losses due to any one accident may not exceed the full amount of your benefit. However, the benefits paid for one loss will not prevent further payment for losses resulting from subsequent accidents.

The Plan provides that no benefits are payable for any loss resulting from:

1. Disease, bodily or mental infirmity or medical or surgical treatment of these: or intentionally self-inflicted injuries, suicide or attempted suicide, while sane or insane.

2. War or any act of war whether or not declared, or service in the armed forces of any country engaged in war or police duty.

3. Participation in a riot or insurrection, or commission of an assault or a felony (no criminal charge or conviction is required).

4. Use of any drug, hallucinogen, controlled substance, or narcotic unless prescribed by a Physician;

5. Driving while intoxicated, as defined by the applicable state law where the loss occurred;

6. Engaging in the following hazardous activities, including skydiving, hand gliding, auto racing, mountain climbing, Russian Roulette, autoerotic asphyxiation or bungee jumping.

CORONAVIRUS (COVID-19) COVERAGE

A. COVID-19 Testing, Diagnostic Services or Items Coverage. Effective March 1, 2020, the Plan will cover charges for tests to detect the SARS-COV-2 or COVID-19 ofthe virus that causes COVID-19 at no cost (meaning no copayment, deductible or coinsurance) for: (a) tests approved, cleared or authorized by the FDA, (b) a test that atest developer intends or has requested FDA authorization for emergency use, (c) a state authorized test and the state has notified the Department of Health and Human Services, and (d) other tests that the Secretary of Health and Human Services determines appropriate in guidance, developed during the COVID-19 public health emergency period. This applies to both in-network and non-network providers.

This COVID-19 coverage also extends to any diagnostic services or items provided during a medical visit including an in-person or telehealth/telemedicine visit (such as virtual check-ins or e-visits) to a doctor's office, urgent care center or an emergency room that results in an order for an administration of the SARS-COV-2 or COVID-19 testing or screening but only to the extent such items and services relate to the furnishing or administration of the test or to the evaluation of the need for a test. Prior authorization or other medical management requirements is not required for diagnostic services related to SARS-COV-2 or COVID-19 testing.

The Plan will reimburse health providers of COVID-19 diagnostic testing at the same rate as previously negotiated before the start of the HHS Emergency Declaration (January 27, 2020) for the duration of the emergency. If the Plan did not have an existing, negotiated rate with a provider before the declaration, the Plan must pay the provider's cash price for the test as listed by the provider on a public website or may negotiate a lower rate. During the emergency declaration period, all providers of a COVID-19 diagnostic test are required to publish the cash price for the test on the providers' public website or be subject to an HHS imposed fine of up to $300 per day.

The following rules also apply:

1. ***Include Coverage of Serological Tests for COVID-19.*** The requirement to coverCOVID-19 tests at no cost extends to serological tests for COVID-19 used to detectantibodies against the SARS-COV-2 virus and are intended for use in the diagnosisof the disease or condition of having current or past infection with CARS-COV-2,the virus which causes COVID-19.

2. ***Includes In-Person and Telehealth Visits for COVID-19 Diagnostic Test.*** Items and services furnished during the office visits is to be broadly interpreted to include both traditional and non-traditional care settings (such as in-person and telehealth visits through LiveHealth Online and drive-through screening and tests where the licensed provider is administering the COVID-19 diagnostic testing).

3. ***Items and services must be provided during a COVID-19 visit.*** Pursuant to DHHS guidance, it is understood that clinicians should use their judgment to determine ifa patient has signs and symptoms with COVID-19 and whether the patient should be tested and are encouraged to test for other causes of respiratory illness. As such,if patient's provider determines that other tests (ex. influenza tests, blood test, etc.) should be performed during the visit to determine the need of such patient for COVID-19 diagnostic testing and the visit results in an order for such test, the Plan will provide coverage for these related tests without cost-sharing when medically appropriate.

B. **COVID-19 Treatment.** Effective March 1, 2020, charges for treatment of the COVID-19 will be covered in the same manner as other medically necessary benefits (80% of network allowance after the deductible) and with out-of-pocket maximums applicable.

C. **COVID-19 Vaccination and Immunization Coverage.** Effective the earlier of January 1, 2021 or fifteen business days after the date on which the United States Preventive Services Task Force ("USPSTF") or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") makes an applicable recommendation relating to qualifying COVID-19 immunizations the Plan, through its medical providers and pharmacy benefit manager, throughout the duration of the COVID-19 public health emergency, will cover approved COVID-19 vaccinations and immunizations. Once it becomes available to the public and subject to future government guidance, COVID-19 vaccinations (and any costs related to antibodies) will be available to all eligible Participants and dependents at no cost whether received in-network and out-of-network and without prior authorization at a doctor's office, medical facilities, governmental health facilities, including participating pharmacies through the Sav-RX pharmacy program.

Subject to further government guidance, the cost of the vaccine itself will be covered by the federal government, but the cost of the administration of the shots will be covered by the Plan.

The Plan has the discretion to deny providers' non-standard and/or excessive charges for vaccines as only a reasonable rate will be reimbursed.

Providers are prohibited from seeking reimbursement from participants and dependents for the vaccine itself including the vaccine administration costs whether as a cost-sharing or balance billing.

D. **Coverage of Certain Over-the-Counter ("OTC") COVID-19 Tests.** Effective for purchases on or after January 15, 2022, the Plan (through Sav-Rx) will provide coverage for, including reimbursement of, OTC COVID-19 tests (known as at-home tests or self-tests): (a) approved, cleared or authorized by the Federal Drug Administration (FDA), (b) tests that received FDA authorization for emergency use, (c) state authorized tests where the state has notified the Department of HHS, and (d) other tests that the Secretary of HHS determined appropriate in guidance during the public health emergency period, to detect the SARS-COV-2 (the virus that causes COVID-19) or the diagnosis of COVID-19, purchased through pharmacies, retail stores and online retailers, without any cost-sharing, prior authorization or medical management requirements and without a prescription or involvement of a health care provider or individualized clinical assessment. Exclusion: The Plan is not required to cover COVID-19 testing that is done for employment purposes.

1. **Cost Limits (Through Pharmacy Network or Direct Coverage).** The Plan will cover 100% of the cost of COVID-19 test obtained at Sav-Rx's in-network pharmacies. Pursuant to the federal guidance, the Plan, through Sav-Rx, will limit reimbursement from a non-preferred pharmacy or other retailers to the lesser of: (i) the actual price of the test or (ii) $12 per test.

In any unique situation in which a Participant is unable to obtain the Test from an in-network pharmacy, the Participant can fill out a form for reimbursement online through Sav-Rx.

2. **Quantity Test limit.** Pursuant to the federal Guidance, the Plan limits OTC COVID-19 tests without a prescription or provider involvement, to no less than 8 tests per covered individual (ex. Participant, Dependent Spouse, Dependent Child) per 30-day period or calendar month. In applying the quantity limit of 8, each test will be counted separately, even if multiple tests are sold in one package.

The Plan may require reasonable documentation prior to providing coverage pursuant to this benefit.

This benefit shall be interpreted in such a manner as to comply with the Frequently Asked Questions 51 and 52 Guidance issued by the Department of Labor, Department of Health and Human Services and the Internal Revenue Service, as it may be amended or clarified. The requirement in this benefit ends effective as of the date the COVID-19 Public Emergency no longer exists.

E. **Prescription Drug Re-fill During Public Health Emergency.** Effective as of March 27, 2020, the Plan's prescription drug refill parameters have been extended to allow Participants to refill maintenance medications when 50% of the current supply has been utilized at retail pharmacies and also at the SAV-RX mail order pharmacy. This is to avoidhaving to visit the pharmacy and risk unnecessary exposure to the COVID-19 virus. Exception: Early refills for any controlled prescription medications or opioids will continueto require prior authorization request to be received from your prescribing physician. Please contact Sav-RX for more information.

EXPANSION OF QUALIFYING MEDICAL EXPENSES UNDER THE HRA – OVER THE COUNTER MEDICINES AND DRUGS AND MENSTRUAL CARE PRODUCTS

Pursuant to the CARES Act, the type of qualifying medical expenses a Participant or dependent may purchase with funds or seek reimbursement (on a pre-tax basis) from their HRA includes (1) over-the-counter (OTC) medicines and drugs without a prescription and (2) menstrual care products (defined as tampons, pads, liners, cups, sponges and similar products used by the individual with respect to menstruation).

HEARING AID BENEFIT

Effective November 1, 2021, the Plan will provide a $1,500 per ear allowance for hearing aid devices with a 36-month frequency limitation period per device beginning on the date of purchase.

A Participant pays the amount in excess of $1,500. This benefit is available to all eligible active Participants and non-Medicare retirees and their dependents. After the 36-month period, the $1,500 per ear allowance renews. To receive reimbursement for hearing aid device purchases up to the $1,500 per ear allowance, the Participant or dependent is required to submit a copy of the itemized invoice and receipt as well as a prescription for the device to the Plan Office. The invoice must include the name of the patient, date of service, description of each service and the amount charged for each service. The $1,500 allowance can be applied to any medically necessary hearing aid device and provider of choice (but see below for an available discount).

Additionally, a hearing aid discount network called TruHearing® has partnered with VSP® to provide exclusive savings to VSP covered Plan members that can be combined with the hearing aid allowance. Discounts through TruHearing on hearing aid devices range between 30% to 60% and include major brands. To take advantage of TruHearing discounts, a Participant or dependent is required to contact TruHearing via the toll-free number **(877) 396-7194** and indicate that he or she has VSP coverage. A TruHearing consultant will then answer questions and schedule a hearing exam with a network provider. At the hearing exam appointment, the network provider will recommend hearing aids that accommodate hearing loss, budget, and lifestyle. The Participant or dependent is responsible for any charges associated with the routine hearing exam and testing. These charges may be submitted through the Health Reimbursement Account (HRA) for reimbursement.

Following the initial TruHearing exam, three free follow-up appointments are included for fittings, adjustments, and ongoing education to ensure satisfaction. These follow-up appointments must be used within the three-year warranty period. Any additional visit beyond the first three appointments will cost up to a maximum of $65 per visit. Additionally, a 45-day trial for each hearing aid purchase is included. If the hearing aids are returned within 45 days of purchase, a full refund will be provided. A Participant or dependent must timely notify the Plan Office in writing if a hearing aid device has been returned and, in turn, refund the Plan Office for the dispersed allowance. A Participant or dependent may submit another reimbursement request upon the next purchase of hearing aids.

If You are Eligible for Medicare (age 65 primarily): You are Required to Enroll (and Pay the Part B Premium)

Medicare is our country's federal health insurance program for people age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin.

Under the Medicare program, the hospital insurance portion is called Medicare Part A and the medical insurance portion, such as for the cost of physicians, outpatient hospital services, certain home health services, durable medical equipment, and other items, is called Medicare Part B. Medicare Part A is financed by payroll taxes, and, if you are eligible to receive Part A based on your own or your spouse's employment, you do not pay a premium. On the other hand, **Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. You must pay this monthly premium, which is $164.90 in 2023, and updated annually by Medicare.**

It is important that you enroll in Medicare Part B when you first become eligible. If you do not, Medicare imposes penalties that will significantly increase your Part B premium once you do enroll. For enrollment and eligibility information, you may call Social Security at (800) 772-1213. You can also find Medicare information on the Internet at www.medicare.gov.

To avoid loss of protection, you must enroll for Parts A and B of the Federal program during the **three months** before the month in which you (or your dependents) will become eligible for Medicare. Please remember that if you and/or your dependent are under age 65 but eligible for Medicare, you and/or your dependent must also enroll in Parts A and B.

Retirees and/or Dependents who are Medicare eligible but fail to enroll in Medicare Parts A and/or B will not be eligible to enroll in the Plan's Medicare Advantage program through Anthem Blue Cross.

ANTHEM BLUE CROSS
STANDARD PRIOR AUTHORIZATION REQUIREMENTS

NOTE: The fact that a procedure is included in this list of Standard Prior Authorization Requirements does not necessarily mean that this Plan covers such a benefit. This Anthem Blue Cross list is subject to change. For a list of Plan services requiring prior authorization, please contact the Trust Fund Office at (408) 588-3753.

Inpatient Admissions

- Elective Admissions
- Emergency Admissions
- OB Related Medical Stay (OB complications, Excludes childbirth)
- Newborn Stays beyond Mother (NICU)
- Inpatient Skilled Nursing Facility
- Rehabilitation Facility Admissions

Home Health/Home Infusion Therapy

Ground and Air Ambulance Services (non-emergency)

Diagnostics

- AmniSure® ROM (Rupture of Membranes) Test
- Computed Tomography Scans with or without Computer Assisted Detection (CAD) for Lung Cancer Screening
- Genetic testing for cancer susceptibility
- Genetic Testing for Inherited Peripheral Neuropathies
- Genetic Testing for PTEN Hamartoma Tumor Syndrome
- Myocardial sympathetic innervations imaging with or without SPECT
- Thyroid Fine Needle Aspirate Molecular Markers

Durable Medical Equipment

- (AAC) Devices/Speech Generating Devices (SGD) Augmentative and Alternative Communication
- Automatic External Defibrillator
- Bone Growth Stimulators
- Cooling Devices and Combined Cooling/Heating Devices
- Insulin Pumps
- Microprocessor Controlled Lower Limb Prosthesis
- Myoelectric Upper Extremity Prosthetic Devices
- Oscillatory Devices for Airway Clearance including High-Frequency Chest Compression (Vest™ Airway Clearance System) and Intrapulmonary Percussive Ventilation (IPV)
- Pneumatic Compression Devices
- Standing Frames
- Wheeled Mobility Devices: Wheelchairs - Powered, Motorized, with or without Power Seating Systems, and Power Operated Vehicles (POVs) (Power Devices), Ultra lightweight manual wheelchairs

Outpatient Treatments, Including Certain Ambulatory Surgical Procedures

- Ablation of Solid Tumors Outside the Liver
- Ablative Techniques as a Treatment for Barrett's Esophagus
- Anesthesia Services for Gastrointestinal Endoscopic Procedures
- Ankle Replacement
- Artificial Disc Placement
- Autologous Chondrocyte Transplantation of the Knee and Ankle
- Balloon Sinuplasty
- Bariatric Surgical Procedures
- Blepharoplasty Procedures
- Bone-Anchored Hearing Aids/Cochlear Implants
- Breast Procedures; including Reconstructive Surgery, Implants, and Other Breast Procedures
- Canaloplasty
- Capsule Endoscopy
- Cardiac Resynchronization Therapy (CRT)
- Carotid, Vertebral and Intracranial Artery Angioplasty with or without Stent Placement
- Chemodenervation of the internal anal sphincter (for diagnosis of anal fissure)
- Chemodenervation of muscles innervated by the facial nerve, unilateral (e.g., for blepharospasm, hemifacial spasm)
- Chemodenervation of neck muscles (e.g., for spasmodic torticollis, spasmodic dysphonia)
- Chemodenervation of extremity and/or trunk muscles (e.g., for dystonia, cerebral palsy, multiple sclerosis)
- Chemodenervation of extraocular muscle (for diagnosis of strabismus)
- Chin Implants
- Computer-Assisted Musculoskeletal Surgical Navigational Orthopedic Procedures
- Contact Laser Vaporization of Prostate
- Cosmetic and Reconstructive Procedures of the Head and Neck
- Cosmetic and Reconstructive Services of the Trunk and Groin
- Cryopreservation of Oocytes or Ovarian Tissue
- Deep Brain Stimulation
- Destruction by Neurolytic Agent
- Electrothermal Shrinkage of Joint Capsules, Ligaments, and Tendons
- Endoscopic Sinus Surgery
- Endoscopic Treatment of GERD
- Extracorporeal Shock Wave Therapy for Orthopedic Conditions
- Extraosseous Subtalar Joint Implantation and Subtalar Arthroereisis
- Facial Dermabrasion/Scar revision
- Focused Ultrasound Ablation of Uterine Leiomyomata
- Gastric Electrical Stimulation
- Gender Reassignment Surgery
- Gynecomastia Repair
- Lumbar Spinal Surgeries
- Nasal surgery for the Treatment of Obstructive Sleep Apnea and/or Migraine Headaches (includes: Excision of Polyp(s), Turbinate(s), Ablation of Turbinate(s), Septoplasty, Repair of Vestibular Stenosis)
- Nasal Implants
- Hyperbaric Oxygen Therapy for the Treatment of Tinnitus
- Rhinoplasty
- Hairplasty

- HALT Procedure
- Hysterectomy
- Implantable Cardioverter-Defibrillator (ICD)
- Implantable Infusion Pumps
- Implanted Devices for Spinal Stenosis
- Insertion/Injection of Prosthetic Material Collagen Implants
- Intensity-Modulated Radiation Therapy (IMRT)
- Intraocular Anterior Segment Aqueous Drainage Devices
- Kyphoplasty Procedures
- Lysis of Epidural Adhesions
- Mandibular/Maxillary (Orthognathic) Surgery
- Meniscal Transplantation
- Manipulation Under Anesthesia of Joints other than the Knee
- Manipulation of Spine under Anesthesia
- Maze Procedure
- MRI Guided High-Intensity Focused Ultrasound Ablation of Uterine Fibroids
- Neuroplasty
- Neurostimulator Implantation
- Occiptal Nerve Stimulation
- Ovarian and Internal Iliac Vein Embolization as a Treatment of Pelvic Congestion Syndrome
- Panniculectomy/Abdominoplasty/Lipectomy/Diatasis Recti Repair
- Partial Left Ventriculectomy
- Patent Foramen Ovale and Left Atrial Appendage Closure for Stroke Prevention
- Penile Prosthesis Implantation
- Percutaneous Neurolysis for Chronic Back Pain
- Photocoagulation of Macular Drusen
- Presbyopia and Astigmatism-Correcting Intraocular Lenses
- Proton Beam Therapy
- Real-Time Remote Heart Monitors
- Removal of Lung
- Rosacea Treatment
- Sacral Nerve Stimulation as a Treatment of Neurogenic Bladder Secondary to Spinal Cord Injury
- Sacroiliac Joint Fusion
- Sclerotherapy/Ablation of Varicose Veins
- Sleep Study
- Somnoplasty
- Stereotactic Radiosurgery/Gamma Ray/Cyberknife
- Subtalar Arthroereisis
- Surgical and Minimally Invasive Treatments for Benign Prostatic Hyperplasia (BPH) and Other Genitourinary Conditions
- Therapeutic Apheresis
- TMJ Procedures
- Transtympanic Micropressure for the Treatment of Ménière's Disease
- Ultrasound Bone Growth Stimulation
- UPPP (Uvulopalatopharyngoplasty)
- Uterine Fibroid Embolization
- Vagus Nerve Stimulation
- Virtual Colonoscopy

Human Organ and Bone Marrow/Stem Cell Transplants

- Heart transplant
- Liver transplant
- Lung or double lung transplant
- Simultaneous Pancreas./Kidney
- Pancreas transplant
- Kidney transplant
- Small bowel transplant
- Multi-visceral transplant
- Stem cell/Bone Marrow transplant (with or without myeloablative therapy)
- Donor Leukocyte Infusion

Mental Health/Substance Abuse (MHSA):

- Facility-Based Care – Acute Inpatient Admissions, Partial Hospitalization, Intensive Outpatient Therapy

ALERT - REMINDER

All of the above items are not necessarily covered by this Plan. This is an overall Anthem Blue Cross List.

ANTHEM BLUECROSS NURSE LINE

24/7 Nurseline provides access to a registered nurse over the phone, anytime, anywhere for assistance or just to hear a reassuring voice at no charge to you. The 24/7 Nurseline program phone number is (866) 670-1565. This program provides:

- A skilled clinical team - RN license
- Bilingual RN's language line & hearing impaired services
- Immediate physician support, as needed
- Personal health counseling
- Comprehensive Audiotape Library

IBEW LOCAL 234 HEALTH AND WELFARE PLAN

ARTICLE I: ESTABLISHMENT AND OPERATION OF THE PLAN AND DEFINITIONS

SECTION 1.01 – PLAN OPERATION

A. ESTABLISHMENT OF PLAN

1. **Restatement of Plan.** The Board of Trustees of the IBEW Local 234 Health and Welfare Trust restates the IBEW Local 234 Health and Welfare Plan with this Summary Plan Description ("SPD"), which is the Plan Document. This SPD is effective as of January 1, 2022.

The Plan is intended to be maintained for the exclusive benefit of Participants and their eligible dependents. It is also intended that this Plan Document shall conform with the Employee Retirement Income Security Act of 1974, as amended (ERISA), including the Affordable Care Act (the 2010 federal health care law).

2. **May Offer Benefits Through Insurance Company and/or HMO.** The Board of Trustees may, from time to time, offer to eligible Employees and Participants the option to elect enrollment through an insurance contract, health maintenance organization, or other form.

B. PLAN MAY BE CHANGED

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

1. terminate or amend either the amount or condition with respect to any benefit even though such termination or amendment affects claims which have already accrued; and

2. alter or postpone the method of payment of any benefit; and

3. amend, terminate or rescind any provision of the Plan; and

4. merge the Plan with other Plans, including the transfer of assets; and

5. terminate insurance company; and

6. restrict coverage to those living only in certain geographic areas.

The authority to make any such changes to the Plan rests with the Board of Trustees. No individual Trustee, Union representative, or Employer representative is authorized to interpret this Plan on behalf of the Board of Trustees or to act as an agent of the Board of Trustees.

C. ADMINISTRATION AND OPERATION

1. **Board of Trustees Responsibilities.** The Plan is administered by a Board of Trustees comprised of up to six Trustees. One-half of the Trustees, called "Employer Trustees," are selected by the National Electrical Contractors Association, Monterey Chapter ("NECA") the Employer Association signatory to a Collective Bargaining Agreement with IBEW Local 234, and one-half of the Trustees, called "Union Trustees," are selected by IBEW Local 234. The current Trustees are listed on page i of this booklet.

The Board of Trustees has many powers and functions including investing the Plan's assets, interpreting Plan provisions, amending the Plan, deciding policy questions, and contracting with advisors and consultants, such as an auditor, legal counsel and benefit consultant.

The Board of Trustees (and persons or entities appointed or so designated by the Board) has the full discretionary authority to determine eligibility for benefits and to construe the terms of the Plan (and other documents pertaining to the Plan and Trust) and any rules adopted by the Trustees.

The Board of Trustees of the Plan is the named fiduciary with the authority to control and manage the operation and administration of the Plan. The Board shall make such rules, interpretations and computations and take such other actions to administer the Plan as the Board, in its sole discretion, may deem appropriate. The rules, interpretations, computations and actions of the Board shall be binding and conclusive on all persons.

2. **Standards of Interpretation.** The Board of Trustees, and/or persons appointed by the Board, shall have the full discretionary authority to determine eligibility for benefits and to construe the terms of this Plan and any regulations and rules adopted by the Board. Only the Fund Manager and/or the Board of Trustees acting upon appeals properly before the Trustees shall have the authority to bind the Trustees to an interpretation of the provisions of this Plan.

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

4. **Employer Contributions.** Employer contributions are made to the Plan pursuant to the terms of the Collective Bargaining Agreement between IBEW Local 234 and Monterey Bay, California Chapter, NECA as well as any individual collective bargaining agreement with IBEW Local 234. Contribution rates for each hour of your Covered Employment are set, from time to time, by the parties to the Collective Bargaining Agreements. Your Employer is required to contribute only for such hours of work that are required by the Collective Bargaining Agreement. The Employer's hourly contribution rate is subject to change at any time if agreed to by the bargaining parties. The bargaining parties also may allocate additional or different contribution amounts to help fund the Plan.

Your Employer is required to make monthly contributions for your Covered Employment and mail (postmark) such payments by the 15th day of the month following the month in which your work was performed. By way of example, January hours generate employer contributions in February which are posted on the Plan's books in March. Each monthly payment made by your Employer is accompanied by a transmittal form that contains the names, Social Security numbers, and hours of work performed by each Covered Employee together with a payment to the Plan. The Employer Contributions to the Plan are not subject to withholding for FICA, FUTA, or state or federal taxes.

IMPORTANT NOTICE: EMPLOYER'S FAILURE TO MAKE CONTRIBUTIONS

Notify the Union and the Trust Fund Office immediately if you believe that your Employer has not contributed and/or is not contributing the full amount on your behalf as required under your Collective Bargaining Agreement. Please refer to your dispatch as a reference.

The Trust Fund Office checks the Employer's report for mathematical accuracy and notifies the Employer if there is any error in the Employer's computations which requires correction.

The amount of Employer Contributions made to the Plan for non-bargaining unit employees (such as employees of the Union, and others not working under a bargaining agreement) will be governed by individual Subscription Agreements entered into with the Plan and any rules adopted by the Board of Trustees.

5. **Loss of Eligibility if no Contributions.** You could lose eligibility with the Plan if the Employer contributions are not timely received by the Plan Office, depending upon your hour bank and how soon the Employer makes the late contributions. If the Employer contributions are eventually received, retroactive eligibility may be granted for a Participant. It is the Participant's responsibility to determine whether he or she has sufficient hours and Employer contributions for eligibility.

6. **Availability of Fund Resources.** It is recognized that the benefits provided through this Plan can be paid only to the extent that the Plan has available adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder, beyond the obligation of a Contributing Employer to make contributions as provided in the 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 this Plan 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 the Collective Bargaining Agreement) in order to provide for the benefits established hereunder.

7. **Funding Methods and Benefits.** The Board of Trustees may provide benefits by self-funding, insurance, an HMO or by any other lawful means or methods upon which the Board may determine. The coverage to be provided shall be determined in the sole discretion of the Board of Trustees and limited to such benefits as can be purchased with the funds available.

8. **Special Exclusion for Fraud.** No benefits will be paid for fraudulent claims of service or supplies by a Participant, eligible dependent, or any other person. If a fraudulent claim has been paid on behalf of any person, both the Employee and any person on whose behalf a fraudulent claim was submitted as a dependent of the Employee will be liable to the Plan for repayment of any benefits paid on behalf of the Employee or any eligible dependent of the Employee against the amount which was fraudulently paid on behalf of the Employee or the other person.

If an Employee or an eligible dependent of the Employee has any outstanding liability for fraudulently paid claims, neither the Employee nor the Employee's eligible dependents may assign any rights to benefits to a provider of services or supplies until all fraudulently paid benefits are repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by an Employee or eligible dependent may be disregarded by the Plan, and payments of benefits by the Plan under a purported assignment is not a waiver of the right of the Plan to refuse to acknowledge other purported assignments. If any fraudulent claims have not been repaid when an Employee or eligible dependent incurs covered charges, the Employee or eligible dependent shall pay all charges directly and file a claim for credit in lieu of benefits, until the entire amount of the fraudulent claims have been credited.

9. **Plan Year.** The Plan Year commences June 1 of each year and ends on May 31 of the following year.

D. YOUR RESPONSIBILITIES

1. **Enrollment Form/Change in Dependent Status.** You should keep your enrollment form current date (add a new spouse and dependent children with required proof).

WARNING – FRAUD AGAINST PLAN

It is fraud if you enroll a dependent(s) that does not meet the Plan's criteria or failing to notify the Trust Fund Office once a dependent no longer meets the Plan's criteria. It is your responsibility to timely notify the Trust Fund Office of any such change. You will be required to repay the Plan for any overpayments or improper payments.

2. **Beneficiary Form.** You should keep your beneficiary form up to date so that family members or others you want to receive your benefits receive them without delay. If you are married, benefits are automatically paid to your legal spouse *unless* he or she consents in writing before a notary. You should submit a new form if there is a change in life circumstance (marriage or divorce).

3. **Privacy Protected Health Information.** There are Privacy Rules and forms to protect you based on recent legislation. If you wish to authorize someone other than yourself to access Plan information, you must complete and submit an Authorization Form to the Trust Fund Office. You may request the Plan's Privacy Notice at any time.

4. **Your Mailing Address.** Be sure to keep the Trust Fund Office advised of changes in your address so that you can continue to receive Plan information because you may be entitled to benefits in the future.

E. FAMILY MEDICAL LEAVE ACT--EMPLOYEES OF LARGER EMPLOYERS

Certain large Employers may have to continue to pay for your health coverage during an approved leave under the federal or state Family and Medical Leave Act (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

1. Your Employer has at least 50 Employees;

2. You worked for the Employer for at least 12 months and a total of at least 1,250 hours during the most recent 12 months; and

3. You require to leave for one of the following reasons:

   a. birth or placement of a child for adoption or foster care,

   b. to care for your child, spouse or parent with a serious medical condition, or

   c. your own serious health condition. Details concerning FMLA leave are available from your Employer.

Requests for FMLA leave must be directed to your Employer; the Trust Fund Office cannot determine whether you qualify. If a dispute arises between you and your Employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments. If the dispute is resolved in your favor, and your Employer makes the required contributions, the Plan will refund the corresponding COBRA payments to you. If your Employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the Employer for contributions made for your coverage during the leave.

SECTION 1.02 – ADMINISTRATOR

As defined by Federal Law, shall mean the Board of Trustees.

SECTION 1.03 – ALLOWABLE EXPENSES

Shall means a health care service or expense, including coinsurance and copayments and without reduction of any applicable deductible, that is covered at least in part by any of the Plans covering the person. If you are covered by more than one medical or dental plan, Allowable Expenses under Coordination of Benefits means any necessary reasonable and customary item of medical or dental expense incurred, a portion of which is covered under one of the plans, covering the person for whom the claim is made. If this is the only plan involved, Allowable Expenses are any necessary, reasonable and customary items of medical or dental expense covered by this Plan. In all cases this Plan's maximum benefit is the limit that will be paid by this Plan. The following are examples of expenses and services that are not allowable expenses:

1. If person is covered by two or more plans that compute benefit payments on the basis of reasonable or recognized charges, any amount in excess of the highest of the reasonable or recognized charges for a specific benefit is not an allowable expense.

2. The amount a benefit is reduced or not reimbursed by the primary plan because a covered person does not comply with the plan provisions (i.e., second surgical opinions, precertification of admissions, preferred provider arrangements) is not an allowable expense

   Effective June 1, 2022, for the following Covered Items and Services under the No Surprises Act only: (1) Emergency services, (2) non-emergency services provided by a Non-Contract Provider at a Contract facility and (3) Covered Air Ambulance Services, the Allowable Charge or Allowable Expense or Covered Expense is the "Recognized Charges/Amount" for Covered Items and Services under the No Surprises Act. See definition for "Recognized Charges/Amounts" below.

SECTION 1.04 – AMENDMENT

Shall mean a formal document changing the provisions of the Plan and approved by the Board of Trustees. Amendments apply to all Covered Persons, including those persons who are covered before the Amendment becomes effective, unless otherwise specified.

SECTION 1.05 – ANCILLARY SERVICES

Shall mean with respect to a Preferred Provider facility:

1. Items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, whether provided by a physician or non-physician practitioner,

2. Items and services provided by assistant surgeons, hospitalists, and intensivists;

3. Diagnostic services, including radiology and laboratory services and subject to exceptions specified by the Secretary; and

4. Items and services provided by a Non-Preferred provider if there is no preferred provider who can furnish such item or service at such facility.

SECTION 1.06 – CONTRIBUTIONS

Shall mean the amount payable by the Employer or the amount payable by the Employer/Employee jointly for participation.

SECTION 1.07 – CONVALESCENT CARE FACILITY

Shall mean an institution which is licensed pursuant to state and local laws and is operated primarily for the purpose of providing skilled nursing care and treatment for individuals convalescing from injury or illness, and

1. is approved by and is a participating Extended Care Facility of Medicare; and

2. has organized facilities for medical treatment and provides twenty-four-hour nursing service under the full-time supervision of a Physician or Registered Nurse; and

3. maintains daily clinical record on each patient and has available the services of a Physician; and

4. provides appropriate methods for dispensing and administering drugs and medicines; and

5. has transfer arrangements with one or more hospitals, a utilization review plan in effect and operations policies developed with the advice of, and review by a professional group including at least one Physician; and

6. is not an institution or part thereof which is primarily a place for rest, a place for custodial care, a place for the aged, a place for drug addicts, a place for alcoholics, a hotel or similar institution.

SECTION 1.08 – COVERED EMPLOYEE

Shall mean an Employee of a subscribing Employer (as defined in the Plan or Trust) who is eligible hereunder and who has been enrolled in the Plan. To be considered as a Covered Employee, the Employee must satisfy the requirements of Article II.

A Participant may be required to certify under penalty of perjury that a dependent meets the requirement of this section.

SECTION 1.09 – COVERED EXPENSES

Shall mean only the fees and prices regularly and customarily charged for Covered Services and Supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Any agreement as to fees or charges made between the Covered Person and the doctor shall not bind the Plan or Trust in determining its liability with respect to expense incurred. Expense incurred is deemed to be incurred on the date on which the service or supply which gives rise to the expense or charge is rendered or obtained.

SECTION 1.10 – COVERED PERSON OR PARTICIPANT

Shall mean a Covered Employee or a Covered Dependent.

SECTION 1.11 – EMERGENCY SERVICES

Shall mean, with respect to an Emergency Medical Condition:

1. Effective June 1, 2022, a medical screening examination (as required under section 1867 of the Social Security Act, 42 U.S.C. 1395dd) that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition, and pre-stabilization services and treatment to stabilize an individual (regardless of the department of the hospital in which such examination or treatment is furnished), and

2. Such further medical examination and treatment (for emergency Services furnished by a Non-preferred provider or Non-preferred emergency facility regardless of the department of the hospital in which such items or services are furnished), to the extent they are within the capabilities of the staff and facilities available at the hospital, as are required under section 1867 of the Social Security Act (42 U.S.C. 1395dd) to stabilize the patient also include post stabilization services (services after the patient is stabilized) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

    a. The provider or facility determines that the participant or dependent is able to travel using nonmedical transportation or nonemergency medical transportation; or

    b. The participant or dependent is supplied with a written notice, as required by federal law, that the provider is a Non-Contract provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any Contract providers at the facility who are able to treat you, and that you may elect to be referred to one of the Contract providers listed; and

    c. The participant or dependent gives informed consent to continued treatment by the Non-Contract provider, acknowledging that the participant or dependent understands that continued treatment by the Non-Contract provider may result in greater cost to the participant or dependent.

Effective June 1, 2022, the emergency department of a hospital also includes an independent freestanding emergency department.

If you require Emergency Care *as* defined above and use the services of a non-PPO Hospital emergency facility or comparable facility, no additional Hospital deductible or reduction of benefits will apply to you. However, if you use the services of a non-PPO Hospital emergency facility or comparable facility and the condition for which you received treatment did not require Emergency Care (that is non-life threatening), an additional $150 Hospital deductible and reduction of benefits will apply. The following benefits are payable from the Plan when you obtain services in an emergency facility:

	INDEMNITY PLAN	
	PPO PROVIDER	**NON- PPO PROVIDER**
Emergency Treatment	80% of negotiated PPO contracted rater after satisfying Annual Deductible plus $150 co- payment*.	80% negotiated PPO contracted rate after satisfying Annual Deductible plus $150 co-payment*.
Non-Emergency Treatment (not life threatening)	60% of the UCR Rate after satisfying Annual Deductible and an additional $150 deductible penalty.	60% of the UCR Rate after satisfying Annual Deductible and an additional $150 deductible penalty.
Out of Country Emergency Claims OUTSIDE OF THE UNITED STATES OF AMERICA, ITS TERRITORIES AND ITS PROTECTORATES	80% of the Monterey County, California UCR Rate after satisfying his or her Annual Deductible plus $150 co-payment. If a UCR Rate cannot be determined, the claim will be paid at 90% of billed charges, not to exceed $500 per day.	
Out of Country Non-Emergency Claims OUTSIDE OF THE UNITED STATES OF AMERICA, ITS TERRITORIES AND ITS PROTECTORATES	60% of the Monterey County, California UCR Rate after satisfying his or her Annual deductible. If a UCR Rate cannot be determined, the claim will be paid at 60% of billed charges, not to exceed $500 per day.	

* Copayment is waived if admitted to the Hospital at the time of visit for emergency care. For emergency treatments with Non-PPO Provider, must transfer to a PPO hospital as soon as it is determined medically feasible.

It will save you money and it will save the Trust money if you use the emergency room only for conditions that require Emergency Care.

Effective June 1, 2022, Emergency Services (as defined in the Definitions section) will be covered:

1. without prior authorization regardless of whether received in-network or out-of-network.

2. without regard as to whether provider furnishing the emergency service is a contract provider or a contract emergency facility, as applicable, with respect to the services,

3. without conditions such as denials based on final diagnosis codes,

4. without regard to any other term or condition of the plan or health insurance coverage other than the exclusion or coordination of benefits, any permissible waiting periods, or applicable cost-sharing requirements,

5. without administrative requirements or limitations that are more restrictive than those applied to in-network emergency services and facilities,

6. Any cost-sharing for out-of-network emergency items and services will not be greater than the in-network cost sharing amount that would apply had the items and services been provided by a participating provider or participating emergency facility,

7. Any cost-sharing payments made by the participant or dependent will count towards the Plan's applicable deductible and out-of-pocket maximums as if the items and services were provided by a participating provider or participating emergency facility.

If you have any questions about using your medical plan, call the Trust Fund Office.

SECTION 1.12 – EMPLOYER

Shall mean any individual Employer (including any individual, partnership, corporation, contractor, joint venture or other entity), the Employer Association, their present and future members, and any other Employer who is required by any collective bargaining agreement to make contributions to this Trust Fund.

The Term "Employer" shall also include the union, which may make contributions to this Trust Fund on behalf of their officers, agents, representatives and employees, provided such contributions do not jeopardize the tax exempt status of the Trust Fund. Said contributions shall be made in such amounts and in such manner as may be required by the Board of Trustees.

SECTION 1.13 – FREE STANDING SURGICAL FACILITY

Shall mean a public or private institution, other than private offices or clinics of Physicians, which meets the official free standing surgical facility requirements of the State Department of Health and the State of California or which, in the absence of such requirements:

1. has been established, equipped, and operated for the purpose of performing surgical procedures by a Physician; and

2. has a permanent plant, equipment, and supplies not usually available in the Physician's office for surgical procedures not requiring Inpatient confinement; and

3. has at least two operating rooms and at least one post-anesthesia recovery room, is equipped to perform diagnostic x-ray and laboratory examinations required in connection with any surgery performed, and has a blood bank or other blood supply; and

4. has full-time services of Registered Nurses (R.N.) for patient care in the operating and post-anesthesia recovery room; and

5. has a written agreement with one or more hospitals in the area for immediate acceptance of patients who develop complications or require post-operative confinement; and

6. has an organized medical staff supervising its operation in accordance with established policy, and maintains adequate medical records for each patient.

SECTION 1.14 – GENDER

He/his and she/her shall apply to both sexes.

SECTION 1.15 – HOSPITAL

Shall mean an institution which:

1. is primarily engaged in providing, by or under the supervision of physicians, to in-patients (1) diagnostic services and therapeutic services for medical diagnosis, treatment, and care of injured, disabled, or sick persons, or (2) rehabilitation services for the rehabilitation of injured, disabled, or sick persons, and

2. maintains clinical records on all patients, and

3. has bylaws in effect with respect to its staff of physicians, and

4. has a requirement that every patient be under the care of a physician, and

5. provides 24-hour nursing service rendered or supervised by a registered professional nurse, and

6. has in effect a hospital utilization review plan, and

7. is licensed pursuant to any state or agency of the state responsible for licensing hospitals, and

8. has accreditation under one of the programs of the Joint Commission on Accreditation of Hospitals.

9. A "Hospital" shall also include a facility that is state licensed and certified for alcohol and drug rehabilitation and is nationally accredited by the Commission on Accreditation of Rehabilitation Facilities (CARF).

Unless specifically provided, the term "hospital" shall not include any institution, or part thereof, which is used principally as a rest facility, nursing facility, convalescent facility or facility for the aged, except as mandated by State Law, or any institution that makes a charge that the covered person is not required to pay.

SECTION 1.16 – HOSPITAL MISCELLANEOUS CHARGES

Shall mean the Network Allowance amounts charged by the hospital for the necessary services, medicines, supplies or services, for diagnosis or treatment of an illness or injury (except services of a physician and drugs or supplies not consumed or used in the hospital) while the Covered Person is hospital confined and a charge is made for room and board or if such services are rendered in connection with a surgical procedure performed on an "Outpatient" basis.

SECTION 1.17 – ILLNESS

Shall mean bodily sickness or disease, psychiatric disorders and congenital abnormalities of a newborn child who is covered as indicated under "ELIGIBILITY."

Illness shall be medically diagnosed and treatment received by a Physician. For purposes of determining benefits payable, illness includes pregnancy of a Covered Person and their Covered Dependent spouse. Illness does not include pregnancy of Covered Dependent children.

SECTION 1.18 – INDEPENDENT FREE STANDING EMERGENCY DEPARTMENT

Shall mean a health care facility that is geographically separate from a hospital under applicable state law and provides emergency services

SECTION 1.19 – INJURY

Shall mean a condition which results independently of illness and all other causes.

SECTION 1.20 – INPATIENT

A Covered Person shall be considered to be an "Inpatient" if treatment requires hospital confinement, including room and board charges.

SECTION 1.21 – INTENSIVE CARE UNIT

Shall mean a section, ward, or wing within the hospital, which is separated from other hospital facilities, and:

1. is operated exclusively for the purpose of providing professional care and treatment for critically ill patients; and

2. has special supplies and equipment necessary for such care and treatment available on a standby basis for immediate use; and

3. provides room and board and constant observation and care by Registered Nurses or other specially trained hospital personnel.

SECTION 1.22 – LIFE THREATENING CONDITION

Effective June 1, 2022, to comply with the No Surprises Act definition of an Emergency Condition, life threatening condition means any disease or condition from which the likelihood of death is probable unless the course of the disease or condition is interrupted, as determined by a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect in the absence of immediate medical attention to result in likelihood of death.

SECTION 1.23 – MEDICAL DEDUCTIBLE AMOUNT

Shall mean the Medical Deductible Amount for each Covered Person during each calendar year shall be the amount shown in the "SCHEDULE OF BENEFITS" and described in the "MEDICAL DEDUCTIBLE" provision.

SECTION 1.24 – MEDICARE

Shall mean Title XVIII (health insurance for the aged) of the United States Social Security Act as amended by Social Security Amendment of 1967 or as later amended.

SECTION 1.25 – NETWORK

Shall mean Anthem BlueCross member physicians, hospitals and allied providers.

SECTION 1.26 – NETWORK ALLOWANCE

Shall mean the contracted fees for services in accordance with the schedule of fees provided by Anthem BlueCross or any successor as selected by the Board of Trustees in its sole discretion.

SECTION 1.27 – NON-EMERGENCY SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDER AT IN-NETWORK FACILITY

Effective June 1, 2022, medically necessary Non-Emergency items, services and visits that are otherwise covered by the Plan (which may include equipment, devices, telemedicine, imaging services, lab work, preoperative and postoperative services) performed by Non- contract providers at In-network facilities (for which the participant or dependent has not knowingly and voluntarily provided consent pursuant to the No Surprises Act patient consent and notice requirements) are covered by the Plan as follows:

1. Cost-sharing will not be greater than the in-network cost sharing amount that would apply if the non-emergency items and services had been provided by a contract provider,

2. Any cost-sharing payments made by the participant or dependent will count towards, if any, the Plan's applicable deductible and out-of-pocket maximums as if the non-emergency items and services were provided by a contract provider, and

3. Non-emergency Health Care Facilities include hospitals (as defined in the Social Security Act Section 1861(e)), hospital outpatient department, critical access hospitals (as defined in the Social Security Act section 1861(mm)(I)) and ambulatory surgical centers (as defined in the Social Security Act Section 1833(i)(1)(A)).

Participants and dependents can knowingly and voluntarily agree to be balance billed including waiving the protections that limit cost-sharing for **Certain Non-emergency services** and **Post-stabilization services** provided the following informed Patient consent and Notice requirements under CAA Section 2799B-2(d) are met:

1. Notice and consent must be provided together and be physically separate from any other documents by Provider/Facility;

2. Must be provided at least 72 hours prior to the scheduled appointment, or if same day no later than 3 hours prior to appointment;

3. Notice and consent must list provider's name, good faith estimate for items or services reasonably expected to be provided, statement that patient is not required to consent (and may instead seek care from an available participating provider/facility and in-network cost sharing will apply in such cases), and must be available in 15 most common languages in the geographic region; and

4. Copy of signed consent must be provided to patient (via in-person or through mail or email) method selected by patient.

However, providers/facilities **cannot** ask participants and dependents to give up protections not to be balance billed for:

1. Emergency services;

2. Air ambulance services;

3. Ancillary services at in-network hospital or ambulatory surgical center, such as emergency medicine, anesthesiology, pathology, radiology, neonatology, assistant surgeon care, hospitalists, intensivists and diagnostic care such as radiology and lab work; and

4. Non-emergency services, if no in-network provider is available or unforeseen urgent medical need or provider furnishes ancillary services that the patient typically does not select.

SECTION 1.28 – NURSE

Shall mean a Registered Nurse (R.N.) or a Licensed Vocational Nurse (L.V.N.).

SECTION 1.29 – OUTPATIENT

A Covered Person shall be considered to be an "Outpatient" if treatment does not require hospital confinement of more than 15 hours.

SECTION 1.30 – PHYSICIAN

Shall mean only a person acting within the scope of their license and holding the degree of:

1. M.D. - Doctor of Medicine
2. D.O. - Doctor of Osteopathy
3. D.M.D. - Doctor of Medical Dentistry
4. D.P.M. - Doctor of Podiatry
5. D.C. - Doctor of Chiropractic
6. Clinical Psychologist
7. Ph.D. - With M.D. or D.O. referral
8. Licensed Clinical Social Worker (LCSW)
9. Marriage, Family, and Child Counselor (MFCC)
10. Licensed Optometrist

Physician shall not include a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person or the Covered Person's spouse as a spouse, parent, child, brother, or sister, whether such relationship is by blood or exists in law.

Benefits for the services of a D.P.M. acting within the scope of their license, are payable only to the extent that benefits under this Plan will not exceed benefits that would have been paid to an M.D. or D.O. for treatment of the given condition.

Services rendered by D.C. are for the diagnosis and correction by manual or mechanical means, including x-rays incidental thereto of structural imbalance, distortion or subluxation in the human body for the removal of nerve interference where such interference is the result of or related to distortion.

Services rendered by a Clinical Psychologist, LCSW or MFCC shall be for any acute (or temporary recurrence of chronic) psychiatric condition, believed to be interfering with the Covered Person's adequate functioning.

SECTION 1.31 – PLAN

Shall mean the benefits and provisions for payment as described herein.

SECTION 1.32 – PLAN ADMINISTRATOR

Shall mean the persons and/or firms employed by the Plan or Trust who is responsible for the processing of claims and payment of benefits, administration, accounting, reporting and other services contracted for by the Plan or Trust.

SECTION 1.33 – PLAN YEAR

Shall mean the twelve consecutive month period beginning with June 1 and ending May 31 of the following year.

SECTION 1.34 – PERMANENT AND TOTAL DISABILITY

Shall mean that the Covered Person, if a Covered Employee, is prevented solely because of a non-occupational injury or non-occupational illness, from engaging in their regular or customary occupation, and is performing no work of any kind for compensation or profit, or if a Covered Dependent, is prevented solely because of a non-occupational injury or non-occupational illness, from engaging in all of the everyday activities of a person of like age and sex in good health, and is under the regular care and attendance of a Physician.

SECTION 1.35 – RECOGNIZED CHARGES/AMOUNTS

Shall mean the negotiated charge contained in an agreement the claims administrator has with the provider either directly or indirectly through a third party.

Effective June 1, 2022, for the following services only: (I) Emergency services, (2) Non- emergency services provided by a Non-Contract Provider at a Contract facility and (3) Covered Air Ambulance Services, the Recognized Charge or Amount means (in order of priority) one of the following:

1. If applicable, the amount determined by All-Payer Model Agreement under Section 1115A of the Social Security Act;

2. If applicable, the amount specified by State law (as applied to plan regulated by state law);

3. The lesser of the billed amount charged by the provider or facility or the Qualifying Payment Amount.

For Air Ambulance Services furnished by Non-Contract providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount.

SECTION 1.36 – QUALIFYING PAYMENT AMOUNT

Shall means the amount calculated using the method described in the No Surprises Act regulations under 29 CFR 716-6(c).

SECTION 1.37 – SERIOUS AND COMPLEX CONDITION

Shall mean with respect to a participant or dependent, one of the following:

1. in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent disability;

2. in the case of a chronic illness or condition, a condition that is a life threatening, degenerative, potentially disabling or congenital; and requires specialized medical care over a prolonged period of time.

SECTION 1.38 – TRUST AGREEMENT

Shall mean the Trust Agreement entitled the "Restated IBEW Local 234 Health and Welfare Trust Agreement" effective January 1, 2010.

SECTION 1.39 – TRUSTEES

Shall mean the Trustees as defined in the Trust Agreement.

SECTION 1.40 – UNION

Shall mean IBEW Local 234 also known as the International Brotherhood of Electrical Workers, AFL-CIO, Local Union No. 234.

ARTICLE II: ELIGIBILITY (ACTIVE AND RETIREES)

SECTION 2.01 – ELIGIBILITY (ACTIVE EMPLOYEES)

Employees are eligible for this coverage if working in a job classification covered by a Collective Bargaining Agreement between Monterey Bay, California Chapter, NECA, and IBEW Local Union No. 234 (or a separate agreement between an individual employer and IBEW Local 234). IBEW Local 234 is the electrician's union for Monterey, San Benito and Santa Cruz counties.

The initial effective date of coverage is the first day of the second month following the month in which an Employee has completed a total of at least 300 hours of work, reported on and paid to the Trust, from one or more contributing Employers.

ELIGIBILITY EXAMPLES

EXAMPLE 1: *You work in January, February and March (100 hours in each month for a total of 300 hours). April is the lag month. Your coverage would begin in May.*

EXAMPLE 2: *You work in January and February (100 hours in each month), but you do not work in March or April. You then work in May and June (50 hours in each month for a grand total of 300 hours). July is the lag month. Your coverage would begin in August.*

Immediate Eligibility of Employees of Newly Signatory Employers. Employees of newly signatory Employers are eligible for benefits on the first of the month following the first month in which contributions are paid to the Plan, pursuant to the terms of a recognized collective bargaining agreement, with certain conditions. The eligibility list must be received by the Plan Office by the third working day of the month and the contribution payment by the fifteenth of the month during which the first contribution is due.

1. Notwithstanding the above, a new employee who becomes enrolled in the Plan because of organizing by theUnion may be granted an advance of a Reserve Account (also known as an "Hour Bank") credit equal to the initial eligibility amount, in accordance with the following: An employee shall be eligible for a Reserve Account advance immediately (first day of the second month) upon notice to the Trust Fund by the Union that, as a part of an organizing effort by the Union: (a) the employee left employment with a non-contributing employer for employment by a contributing employer; or the employee's employer is newly contributing; and (b) the employee is employed by a contributing employer.

2. An employee who qualifies for an advance shall be covered under the Plan as if the initial eligibility amount had been credited to the employee before the first day of the month in which the employee became enrolled in the Plan, except that no benefits shall be provided for the period before the date that the employee first worked for a contributing employer in that month. By way of example, if an employee for a newly organized employer performs Covered Employment in February, he will be entitled to coverage under the Plan as of April 1. An Employee who obtains the immediate coverage notwithstanding having initially earned 300 hours, will have an offset of future hours in excess of 120 hours to offset the hours that had been advanced to the Participant. The Participant has twelve months in which to work sufficient hours to offset the hours that were advanced.

3. An employee may use an advanced Reserve Account on the same basis as a regular Reserve Account, except as follows:

   a. No further Reserve Account may be accrued until the Reserve Account accrued for contributions actually received on behalf of the employee is equal to the amount advanced to the employee's Basic Reserve Account within the twelve month period specified above; and

   b. The advanced Reserve Account amount shall be revoked immediately if the employee ceases to work in, or to be available for, Covered Employment.

SECTION 2.02 – RESERVE ACCOUNT/HOUR BANK

The term "Reserve Account" means an account of hours that is established for each Active Employee, but not for Non-Collective Bargaining Employees. Hours are credited to and deducted from the Reserve Account as follows:

1. **Reserve Account.** All hours worked for each subscribing Employer are credited to the Reserve Account on the first day of the second month following the month in which the hours were worked, except as otherwise provided in item 3 of this Section.

2. **120 Hours Deducted.** 120 hours are deducted from the Reserve Account for each month during which an Employee is covered.

3. **Maximum Hours - Hour Bank.** The maximum number of hours allowed in the Reserve Account is 960 hours after the 120-hour deduction has been made for the current month's coverage. **The Board of Trustees may eliminate or change the maximum Reserve Account amount at any time. There is no vested right to such Reserve Account hours.**

4. **Inactivity/Hours Forfeited if no Activity During 12 Consecutive Months.** If there has been no activity in the Reserve Account throughout a period of twelve consecutive months, any remaining hours shall be forfeited at the end of that period, except as otherwise provided in item 5 of this Section. For reinstatement, refer to Section 2.13.

5. **Election to Freeze Hour Bank.** If the Reserve Account contains at least 120 hours at the time an Employee stops working for a contributing Employer, he may choose to have all of the hours kept in his Reserve Account for a period of up to one year. The Trust Fund Office must receive notice of this choice within 30 days after an Employee stops working for his Employer. (The "120" hour amount may be increased at any time.)

If notice is received before the 15th day of the current month, deductions from the Reserve Account shall stop on the first day of the next following month; otherwise, the deductions shall stop on the first day of the second month following the month in which the notice is received. The Employee's account shall be reactivated when the Trust Fund Office receives written notice from the Employee or upon contributions being made by a contributing Employer for bargaining unit employment of the Employee.

6. **Employment with a Noncontributing Employer.** If you become employed by an employer in the electrical industry that does not contribute to an IBEW-sponsored health and welfare plan, the balance in your Hour Bank will be immediately canceled.

7. **Option to Buy-Up Coverage for One Month if Insufficient Hour Bank**

If a Participant's Reserve Hour Bank Account falls below 120 hours, the Participant will have the option to buy-up coverage under the Plan for one month at the current Employer contribution rate to bring his or her hours up to 120 in order to continue enrollment in the Plan. The Plan may require that the payment for such coverage be received by the Plan Office by a specified due date (such as the 20th day of the month for coverage starting the 1st of the following month).

SECTION 2.03 – RECIPROCITY

The Board of Trustees of this Plan realizes that you may work in several locations and in the jurisdiction of other local union Trust Funds during your career. This Plan participates in the Electrical Industry National Reciprocity Agreement with certain other IBEW Health and Welfare Plans, which provides for "Money Follows the Person" reciprocity.

To maintain your Hour Bank balance (and therefore qualify for coverage under the Plan), you may apply to have contributions that have been made to another IBEW-NECA sponsored health and welfare plan on your hours worked (the "Participating Fund") transferred to the Plan and treated as Covered Employment in accordance with procedures set forth in the Reciprocal Agreement. Your application must designate this Plan as your "Home Plan," and you must (i) register on the Electronic Reciprocal Transfer System ("ERTS"), (ii) present valid photo identification at the Plan Office, the Participating Fund, or an assisting IBEW local union, (iii) agree to be bound by your electronic signature on ERTS and (iv) agree to the transfers in such manner as the Reciprocal Agreement, and the Plan may require. The effective date of the transfer is the first day of the month in which you have properly registered in ERTS and met the Home Plan eligibility requirements described in subsection (b). The Reciprocal Agreement provides that, upon approval of your application, contributions will be transferred to the Plan to the extent of the lesser of (i) the amount provided in the current Collective Bargaining Agreement or (ii) the amount provided in the current collective bargaining agreement of the Participant Fund. If the Collective Bargaining Agreement's contribution rate is greater than the rate in the Participating Fund's collective bargaining agreement, your credit will be adjusted accordingly. The Board of Trustees has the total and absolute discretion to determine whether you are eligible to have this Plan be designated as your Home Fund.

SECTION 2.04 – SELF PAYMENTS FOR LIMITED PERIOD (UP TO 3 MONTHS)

If the balance in the Reserve Account falls below 120 hours for any reason except stopping work because of disability or retirement, or if an Employee is still temporarily disabled after the end of the continuation of coverage provided by Section 2.09, paragraph 1, an Employee may continue the coverage for an additional period of not more than three consecutive months beyond the date it would otherwise end by paying the required self-contribution to the Trust Fund before the 15th day of each month (received by that date) during which the coverage is to be continued. If the Employee fails to make a timely required payment, the coverage shall end and the Employee shall then qualify for coverage only in accordance with the Reinstatement Section 2.13.

SECTION 2.05 – CONTRIBUTIONS

An Employee, retiree and/or his dependents may be required to contribute toward the cost of the coverage provided in the Plan.

SECTION 2.06 – COVERAGE DURING DISABILITY

1. An Active Employee with five years (60 consecutive months) of continuous coverage who has coverage on the date he becomes temporarily disabled and receives Workers' Compensation Benefits, Social Security Benefits or disability benefits provided under the California Unemployment Insurance Code, the Employee may request in writing to the Board of Trustees that he be placed on the Temporarily Disabled List. Upon approval of the Board of Trustees, the Employee shall, on the expiration of his reserve hours (if any), have the Health and Welfare benefits paid on his behalf by the Plan until recovery or for a period not to exceed 12 months, whichever occurs first.

   If an Employee recovers within the twelve month period, the Employee shall not be eligible for Temporary Disability Coverage again until the Employee has returned to Covered Employment or has registered for immediate employment and twelve consecutive months have elapsed since the last month for which the Trust Fund provided the Employee Temporary Disability Coverage.

If an Employee is on the Temporary Disabled List and receives any benefits from an IBEW-affiliated Retirement Plan, other than a disability pension, the Employee's coverage shall immediately terminate and the Reserve Account shall be forfeited.

2. If an Employee recovers from a temporary disability while coverage is being continued as shown above, and the Employee registers for immediate employment with a subscribing Employer, the Trust shall pay the premiums required to continue coverage for three months beyond the recovery date.

3. If an Active Employee is eligible for coverage and then becomes permanently and totally disabled so that he cannot work for wages or remuneration, he shall be placed on the Retiree List upon securing a Social Security Award and he shall be covered as a Retired Employee for as long as he remains permanently and totally disabled. It is the Employee's responsibility to timely notify the Trust Fund Office of the Social Security Award (within 30 days of such notice). The Board of Trustees may require proof of permanent and total disability at any time.

4. For an individual who has served as an apprentice in the IBEW Local 234 Joint apprenticeship Program for at least twelve months and has had coverage under the Plan for at least twelve months who incurs a disability while in the status of an apprentice which precludes the apprentice from working in Covered Employment, and the disability is expected to last for at least six consecutive months, the apprentice may be entitled to continued coverage under the Plan for an additional period up to twelve months at no charge to the apprentice subject to approval by the Board of Trustees. This benefit may be extended if approved by the Board of Trustees and/or the Chair and Co-Chair of the Plan. **This benefit is not available for any apprentice who performs work in non-covered employment in the electrical industry during the period of the disability or during the prior twelve month period.**

SECTION 2.07 – ELIGIBILITY (EARLY RETIRED EMPLOYEES)

Employees are eligible during early retirement for benefits under this Plan provided that (a) the Employee timely pays a self-contribution in the amount determined by the Board of Trustees, (b) the Employee is at least 55 years of age, and (c) the Employee meets all of the requirements specified below for Retired Employees, except for age.

The effective date of early retirement coverage shall be the date of retirement as an eligible Early Retired Employee on or after age 55. To maintain continuous coverage, the monthly payment required by the Board of Trustees must be **received** in the Trust Fund Office before the 15th day of the preceding month for which coverage is to be provided. If an Employee fails to make a required payment when due, the early retirement coverage shall terminate permanently. An Employee may become covered again only if he re-qualifies under the Eligibility rules that apply to Active Employees.

The early retirement coverage shall consist of the benefits for an Employee and his Dependents in force while the Employee was an Active Employee; however, the Board of Trustees reserves the right to change or discontinue the early retirement coverage to those covered at any time.

If continuous early retirement coverage is maintained until an Employee reaches age 62, and if the Employee meets the requirements of Section 2.08 below, the Employee shall become covered under the coverage provided at that time for Retired Employees.

An Employee shall not be eligible for early retirement coverage or, if covered, coverage shall automatically terminate if an Employee becomes eligible for coverage under another plan of group coverage which is provided through active employment.

A Retired Employee who has qualified for coverage as an Early Retiree under this Section shall, if he or she returns to Covered Employment under the Plan, continue to be able to make self-payments at the Early Retiree Self-pay rate established by the Board of Trustees until coverage is obtained as an Active Employee based on hours worked.

If such an Early Retiree, after returning to Covered Employment, then terminates his or her Covered Employment and then leaves active coverage but then signs up on the out-of-work list, such Early Retiree may pay the Active/Self Pay rate for the first three months on self-pay and after that three-month period, will be required to pay the Early Retiree Rate.

Non-Bargaining Alumni Employees who retire are Eligible for Retiree Medical Coverage

A non-bargaining unit employee who is an alumni employee of the Plan (he or she previously participated in the Plan as a bargaining unit employee) who retires is eligible for retiree medical coverage in the same manner (same eligibility rules) as retired bargaining unit employees are under this Section of the Plan as well as Section 2.08 of the Plan. Such individuals are not eligible for such coverage if they have worked in a position in the electrical industry for an employer that did not contribute to the Plan.

SECTION 2.08 – ELIGIBILITY (RETIRED EMPLOYEES – AGE 62 OR OLDER)

A Retired Employee and his eligible Dependents shall be eligible for coverage if each of the following eligibility requirements are met:

1. Attained at least 62 years of age.

2. Had continuous coverage under the Plan for the last 96 months or for at least 180 of the last 216 months immediately before retirement date and have continuous coverage for the 12 months immediately preceding the date of retirement.

3. Provide satisfactory evidence of employment in Covered Employment or available and actively seeking such employment immediately before retirement date.

4. Months of coverage resulting from COBRA payments made by the Participant pursuant to Article IV, or payments or coverage granted by the Trust pursuant to Section 2.09 shall be counted in calculating the months of coverage required by paragraph 2 above. Thus, periods in which the Participant is covered under the Plan as a result of making COBRA payments are counted in determining whether the Participant had continuous coverage for the 12 months immediately preceding the date of retirement.

The effective date of retirement coverage shall be the date of retirement as an eligible Retired Employee.

A Retired Employee who has qualified for coverage as a Retired Employee under this Section shall, if he or she returns to Covered Employment, continue to be able to make self-payments at the Self-pay rate (for Retirees his or her age) established by the Board of Trustees until coverage is obtained as an Active Employee based on hours worked.

If a retiree under the Plan is Medicare-eligible, returns to Covered Employment, but then goes back on the out-of-work list (rather than retiring again), the Retiree would pay the Plan's Retiree Age 65+, Medicare self-pay rate as long as he or she is no longer working and Medicare is primary.

ALERT - RETIREE BENEFITS ARE NOT VESTED.

INITIAL ELIGIBILITY AND CONTINUING ELIGIBILITY FOR RETIREE COVERAGE DEPENDS ON THE BOARD OF TRUSTEES CONTINUING THE RETIREE BENEFITS. THE BOARD OF TRUSTEES RESERVES THE RIGHT TO CHARGE FOR, MODIFY AND/OR TERMINATE THE RETIREE BENEFITS AT ANY TIME. RETIREE BENEFITS ARE NOT A VESTED RIGHT.

THOSE AGE 65 OR OLDER: YOU ARE REQUIRED TO ENROLL IN MEDICARE

1. **Summary of Medicare.** Medicare is our country's federal health insurance program for people who worked at least 10 years in Medicare Covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin. If you are not a citizen or permanent U.S. resident, you may not qualify for Medicare.

   Under the Medicare program, the hospital insurance portion for inpatient care and certain skilled nursing facilities is called Medicare Part A, and the medical insurance portion, such as for the cost of physicians, is called Medicare Part B. Part B covers medical and doctor services, outpatient hospital care and other services. The member pays an annual deductible and 20% coinsurance. Members continue to pay the Part B premium monthly out of their Social Security check.

   If a person declines Part B when first eligible, the cost of enrolling in Part B at a later date may be increased by 10% for each full 12-month period that they should have had Part B. The Part B penalty can be waived if a person is still actively employed or their spouse is actively employed and the person has health insurance coverage under an employer/union group health care plan (the employer must have more than 20 employees).

   Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums paid by individuals enrolled for Part B coverage. Most people are entitled to Part A when they turn age 65 and pay no premium because they or a spouse paid Medicare taxes while working.

SECTION 2.09 – ELIGIBILITY (NON-COLLECTIVE BARGAINING EMPLOYEES)

An Employee becomes an eligible Non-Collective Bargaining Employee on the later of the following dates, provided that he is a full-time, permanent, non-seasonal Employee working at least 30 hours per week in a job classification not covered by a Collective Bargaining Agreement:

1. The first day of the month coinciding with or next following the date an Employer becomes a contributing Employer to this Plan as approved by the Board of Trustees.

2. The first day of the month following the month in which an Employee is employed by a contributing Employer.

All eligible non-bargaining unit Employees and their eligible Dependents shall be covered, whether or not they are covered under another plan; however, non-collective bargaining Employees are **NOT** eligible for retiree benefit, except for employees of the Union.

SECTION 2.10 – COVERED DEPENDENT

Means a lawful spouse and the Participant's children up to the end of the month in which a child attains age 26.

1. LAWFUL SPOUSE

An eligible Dependent includes the Participant's lawful spouse (including opposite-sex and same-sex spouses) who is not legally separated from the spouse in any form. A spouse becomes eligible as of the date of marriage, provided that you have submitted an updated Enrollment/Change Form adding your spouse along with a copy of your certified marriage certificate within 30 days of the date of marriage. If an updated Enrollment/Change Form and proper documentation is not received within 30 days of the date of marriage, enrollment in the Plan for your spouse will not be effective until the first of the month following receipt of the required documentation.

California law and this Plan do not recognize a common law marriage.

A former spouse is NOT eligible for coverage as a Dependent under the Plan, and a Participant may not enroll a former or Separated Spouse, even if a court orders such coverage, **except as required by COBRA.** Separated Spouse or former spouse may, however, be eligible to elect to pay a premium to continue medical, prescription drugs, dental, and vision coverage under COBRA Continuation of Coverage.

It is the obligation of the Plan Participant and Separated or divorced Spouse to notify the Trust Fund Office in writing within 30 days of the date of any form of a legal separation and/or a divorce.

2. CHILDREN THROUGH 25 YEARS OF AGE

A Participant's Dependent Child(ren) through age 25 who meets all other Plan requirements is eligible to enroll and be maintained as a Dependent regardless of whether the Dependent Child(ren) is eligible for coverage under another employer-sponsored group health plan through his or her own employment or Spouse's employment.

Enrollment of a Dependent Child(ren) would be subject to Enrollment procedures the Health and Welfare Plan, including completion of an Enrollment/Change Form and submission of all other Plan required documents/information.

Dependent children include the Participant's:

a. Natural Child(ren).

b. Stepchildren. The Plan requires that before a stepchild(ren) can be enrolled in the Plan, any legal documents must be timely submitted to the Trust Fund Office. The Plan has no obligation to continue coverage for a stepchild(ren) once the stepchild(ren)'s natural parent (Participant's Spouse) separates*, in any form, from a Plan Participant.

c. Legally Adopted Child(ren) by the Plan Participant and/or Lawful Spouse. If a Participant has not legally adopted a child(ren), the Plan has no obligation to continue coverage for a child(ren) once the Spouse who legally adopted the child separates*, in any form, from a Plan Participant.

d. Child(ren) for whom the Participant and/or Lawful Spouse has Court-Appointed Legal Guardianship of the Person. The Plan might consider a child(ren) for whom the Participant's Lawful Spouse has been court appointed as sole legal guardian of the person, provided the child(ren) is related to the Participant by blood or marriage. If the Participant is not named as a Court-Appointed Legal Guardian, the Plan has no obligation to continue coverage for a child(ren) once there is a legal separation or a divorce from the Participant. No coverage will be provided in the child is on active duty in the armed forces.

In order to enroll and maintain enrollment of a Dependent Child(ren), the Participant is required to provide the Plan Office with a copy of any legal documents establishing a Dependent Child(ren) relationship to the Participant. In addition, the Plan may require documentation that establishes a Participant's obligation to provide Health coverage. This includes, but is not limited to, birth certificates, decree of adoption, court ordered legal guardianship papers or a Qualified Medical Child Support Order for a natural child(ren) who does not reside in the Participant's home. Child(ren) for whom the Participant has Court-Appointed Temporary Legal Guardianship, the Plan will require status updates periodically until permanent guardianship has been obtained and permanent guardianship papers have been submitted to the Trust Fund Office.

Dependent shall be eligible for Dependent coverage on the later of (a) the date an Employee is eligible for coverage, or (b) the date the person qualifies as an Eligible Dependent, except as stated in Section 2.14 - Deferred Effective Dates.

3. DISABLED DEPENDENT CHILD

Covered Dependent child, who is incapable of self-sustaining employment because of mental retardation or physical handicap and is chiefly dependent upon the Employee for support, shall not have his or her medical coverage terminated because of reaching the maximum age limit; however, the Board of Trustees may establish an age limit at any time in the future for such disabled adult children and/or require additional premiums for such coverage or provide for any other special rules.

The Trustees may charge a higher rate of premium for Dependent Children over age 26, at any time. The Board reserves the right to set an age limit on Plan coverage of Disabled Dependent Children in the future and may terminate such coverage at any time.

The Participant must be able to furnish proof to the Plan Office periodically and upon request that the Dependent Child(ren) meets all Plan requirements including the Dependent's continued disability.

To be entitled to coverage after attainment of age 16, the Dependent Child(ren) must have been continuously covered as an eligible Dependent prior to attainment of age 26; Moreover, the Dependent Child(ren) must have become totally and permanently disabled and incapable of self-sustaining employment by reason of mental retardation or physical handicap prior to age 26 while covered under the Plan.

SECTION 2.11 – QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMCSO) / NATIONAL MEDICAL SUPPORT NOTICE (NMSN)

The Plan will comply with a court order or National Medical Support Notice (NMSN) that requires the Plan to provide coverage for a Participant's Child(ren) if it meets the standards of a Qualified Medical Child Support Notice (QMCSO); however, no such order may require the Plan to provide benefits to someone who would not otherwise meet the Plan definition of an eligible Dependent Child(ren) nor can such an order require the Plan to provide benefits in excess of benefits provided under the Plan or to provide coverage to a Child(ren) who resides outside of the Plan's Health Plan service areas. The Participant must timely provide the Trust Fund Office with a copy of any court order or NMSN that establishes the Participant's legal obligation to maintain coverage on a Dependent Child(ren), including a QMCSO. A QMCSO recognizes an eligible Child(ren)'s right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The Child(ren) must meet the Plan requirements of an eligible Dependent Child(ren) and will be covered through age 25. Coverage may terminate earlier than age 26 if the QMCSO and/or NMSN states such.

SECTION 2.12 – CONTINUATION OF DEPENDENT COVERAGE AFTER DEATH

The Trust shall provide Dependent coverage after the Covered Employee's death, but the coverage shall not continue beyond the date the surviving spouse remarries. Coverage for a Dependent child shall not continue beyond the date the child attains the maximum age limit set forth in Section 2.10. The Plan may charge for such coverage.

SECTION 2.13 – REINSTATEMENT

If an Employee returns to active work as an eligible Employee after his coverage has ended, the coverage will be reinstated on the first day of the second month following the month in which the Employee accumulated (has been reported and paid) a total of at least 120 hours of work for one or more contributing Employers. An Employee that has not had activity in his account for twelve months as set forth in Section 2.08(4) shall reestablish eligibility as set forth in Section 2.01.

SECTION 2.14 – DEFERRED EFFECTIVE DATES

If an Employee is prevented by a disability from performing the duties of his regular occupation or from engaging in the normal activities on the effective date of an increase in benefits, the coverage or increase shall not apply until the first day of the month next following the date on which the disability ends, except that on the date coverage would otherwise be reinstated after it had previously terminated, the terms of the following paragraph shall apply.

SECTION 2.15 – BENEFIT CHANGES

Changes in coverage due to a change of classification shall take effect on the date of the classification change.

An Employee not available for active work on the date coverage would otherwise be reinstated, the coverage shall not be reinstated until the date on which the Employee is available for full time work.

If a Dependent, other than a newborn child, is prevented by a disability from engaging in his everyday activities on the effective date of his coverage or on the effective date of an increase in benefits, the coverage or increase shall not apply to him until the first day of the month next following the date on which the disability ends.

SECTION 2.16 – ONE-TIME OPT-OUT/RE-ENROLL WITH PROOF OF COVERAGE

An active or retired Participant and/or a spouse (and/or other dependent) may elect to opt out of coverage under the Plan (because of coverage under another Plan or for other reasons) and later re-enroll in the Plan on the condition that proof of continuing coverage under another Plan during the opt out period is provided in a timely manner.

SECTION 2.17 – HEALTH REIMBURSEMENT ACCOUNTS

1. **HRA.** The Board of Trustees establishes an Individual Account for the Participants known as a Health Reimbursement Account ("HRA") to be funded by Employer contributions and/or transfers from the Plan's reserves and/or earnings. The Board of Trustees is authorized, at the Board's discretion, to transfer funds from the Plan's reserves to the Participants' Health Reimbursement Accounts ("HRA"). Such Accounts are limited to active Participants (but may be used when the Active Participant becomes a retired Participant). Each active Participant for whom Employer contributions are made to an HRA will have such contributions allocated to his or her Individual Account. Such contributions are Employer contributions as required by the Internal Revenue Code. The Board of Trustees may delegate responsibility for administration of the HRA to the third party administrator and/or to a firm that specializes in HRA administration.

The Board of Trustees, or the Board's delegate, will provide you with a Card, also known as a "Debit Card" or "Benny Prepaid Card", to access your HRA Account. Your Benny Prepaid Card will be loaded with the available balance of your HRA (less any amounts already spent) and is updated regularly. The Card is used to pay for qualified health care expenses. You may use your Card to pay for items, such as but not limited to:

a. Covered prescription co-pays
b. Lasik surgery and eyeglasses
c. Health Plan deductibles
d. Health Plan co-insurance (co-pays)
e. Orthodontics
f. Out-of-pocket dentist fees
g. Doctor and emergency room co-pays

This list is not intended to be all-inclusive. See also Section 5. below.

2. **No Vested Right to HRA Account/No Cash Death Benefits.** There is no vested right to an HRA balance. Moreover, pursuant to the Internal Revenue Code and lawful regulations issued thereunder, no cash death benefits are payable from an HRA. If the law changes, then such cash death benefits may be payable.

   A Participant's HRA Account will be forfeited to the general reserves of the Plan if he or she becomes employed in the Electrical Industry for an Employer that does not contribute to the IBEW Local 234 Health and Welfare Plan or other Plan in which an IBEW Local Union has appointed Trustees to administer the Plan.

   Pursuant to IRS Notice 2013-54 and Department of Labor Frequently Asked question Guidance (Part XXII) issued on November 16, 2014, HRA balances may not be used to reimburse the premiums of individual health insurance policies.

3. **Allocate Earnings or Losses.** HRA Accounts that have a year-end balance may be credited (or charged) an amount reflecting the interest (or loss) on the account for the Plan Year, at the discretion of the Board of Trustees. Regardless of whether interest or losses are allocated to HRA Accounts, the Board of Trustees reserves the power to assess an administrative charge against each HRA Account. There is no requirement that earnings or interest be allocated to an HRA Account inasmuch as the Plan incurs expenses related to the HRA and interest rates have been and continue to be low. The Board of Trustees may, however, at its discretion, establish an annual interest allocation to the HRA Accounts.

4. **Purpose of HRA/Other Plan Premiums/Payments.** An HRA Account may be used for eligible medical expenses not covered under the Plan, such as the deductible and/or co-payments. In addition, a Participant may use his or her HRA Account to make Self- Payments and/or COBRA payments for his or her coverage under the Plan, when otherwise eligible to make Self-Payments or COBRA payments. A surviving spouse or surviving eligible dependent of a deceased Participant may use the Participant's HRA balance for unpaid medical expenses (such as the deductible or co-payments) and/or make monthly payments or to pay premiums for COBRA coverage based on the death of the Participant as the qualifying event or otherwise use the balance in the Participants' HRA Account.

5. **Qualified Expenses.** A debit card will be issued to each Participant which will show the value of his or her Health Reimbursement Account. This Card will be used to pay the qualified expenses (except that self-payments and COBRA payments may be taken directly from the HRA balance). To qualify for payment through a Participant's HRA Account, a Participant must have funds in his or her Account before having any expenses/payments reimbursed or made. An expense must satisfy all of the following requirements:

   a. The expense must have been for medical care as defined in Internal Revenue Code § 213(d), except as follows: An expense for premiums for medical coverage shall be reimbursable only if: (i) the expense is authorized pursuant to the Plan and this or any Amendment; or (ii) the Participant is on Self-Pay or

      COBRA or covered as a retiree, and the premium is for coverage of a dependent under insurance or a group health plan other than this Plan.

   b. The expense must have been incurred by the Participant or by a person who was then either a covered eligible dependent of the Participant or a dependent within the meaning of the Internal Revenue Code§ 152.

   c. The claim for HRA Account benefits must be made within one year of the time the expense was actually incurred. Extensions of this time limit will be granted only for good cause shown, at the sole discretion of the Board of Trustees.

d. The expense must have been incurred on or after December 1, 2016.

e. The Participant or dependent may be required to provide proof, satisfactory to the Trustees, that the claim satisfies the requirement of this section.

6. Procedures for Payment of Benefits/Opt out of Benefits/ Interplan Transfer

a. Benefits will be paid only to a Participant or surviving eligible dependent. Benefits will be paid only after an eligible person has incurred a Qualified Expense through use of the HRA Debit Card. Assignment of HRA Account benefits to others is not allowed.

b. An employee is permitted to permanently opt out of and waive future reimbursement from the HRA Account.

c. If an Employee has an HRA account that is sponsored by another IBEW Local Union's Health and Welfare Plan and that Plan executed an inter-plan transfer agreement with this Plan, the Plan may transfer the Employee's entire HRA Account to that other Plan. Once that occurs, the Employee has no rights or any benefits with this Plan.

7. Forfeiture After Death. The HRA Account of a deceased Participant shall be forfeited under the following circumstances:

a. if the Participant dies without any dependents eligible for any form of extended benefits under this Plan and/or the Internal Revenue Code; or

b. if the Participant's surviving eligible dependents elects not to maintain coverage under the Plan.

8. Effect of Forfeitures. Forfeitures shall be used to pay Plan expenses and/or becredited to the HRA Accounts of other Participants, in the same manner as earnings.

The Board of Trustees has the discretion, if financial conditions within the Health and Welfare Plan require such, to allocate funds that have previously been allocated to the HRA accounts, to be used to pay Plan benefits and expenses for the overall benefit of the Plan in general.

HRA ELIGIBLE EXPENSES: What's Eligible?

The IRS defines eligible health care expenses as amounts paid for the diagnosis, cure, mitigation or treatment of a disease, and for treatments affecting any part or function of the body. The expenses must be primarily to alleviate a physical or mental condition or illness. The products and services listed below are examples of medical expenses eligible for payment under a Health Reimbursement Account. This list is *not meant to be all-inclusive*. Moreover, items could be on the list that are not covered by this Plan. Such expenses must be medically necessary. IRS regulations could also change this list.

Eligible Expenses

DENTAL SERVICES

Dental X-Rays
Dentures
Exams/Teeth Cleaning
Extractions
Fillings
Gum Treatment
Oral Surgery
Orthodontia/Braces
Crowns/Bridges

VISION SERVICES

Optometrist/Ophthalmologist/Optician
Eye Examinations
Eyeglasses
Contact Lenses
Laser Eye Surgeries
Artificial Eyes
Prescription Sunglasses
Radial Keratotomy/LASIK

MEDICAL TREATMENTS/PROCEDURES

Acupuncture
Alcoholism and Drug Addiction (inpatient treatment)
Breast Reconstructive Surgery
Hearing Exams
Hospital Services/Surgeries/Inpatient
Infertility
In Vitro Fertilization
Norplant Insertion or Removal
Physical Examination (not employment-related)
Physical Therapy
Reconstructive Surgery (if medically necessary due to a congenital defect or accident)
Speech Therapy
Sterilization
Transplants (including organ donor)
Vaccinations/Immunizations
Vasectomy and Vasectomy Reversal
Weight Loss Program (prescribed by doctor)
Well Baby Care

OBSTETRIC SERVICES

Lamaze Class (child rearing classes excluded)
Midwife Expenses
OB/GYN Exams
OB/GYN Prepaid Maternity Fees (reimbursable after date of birth)
Pre and Postnatal Treatments

LAB EXAMS/TESTS

Blood Tests
X-Rays
Cardiographs
Laboratory Fees
Metabolism Tests
Urine/Stool Analysis

MEDICATION

Insulin
Prescribed Birth Control and Vitamins
Prescription Drugs

PRACTIONERS

Allergist
Anesthetist
Chiropractor
Christian Science
Dermatologist
Homeopath
Naturopath
Neurologist
Orthopedist
Osteopath
Physician
Psychiatrist
Psychologist

MEDICAL EQUIPMENT, SUPPLIES AND SERVICES

Abdominal/Back Supports
Ambulance Services
Arches/Orthopedic Shoes
Contraceptive, prescribed
Counseling
Crutches
Hearing Devices and Batteries
Hospital Bed and services
Learning Disability (special school/teacher)
Medic Alert Bracelet or Necklace
Oxygen Equipment
Prescribed Medical//Exercise Equipment
Prosthesis
Splints/Casts or Support Hose
Syringes
Transportation Expenses (essential to medical care)
Tuition Fee at Special School for Disabled Child
Weight Loss Drugs (to treat specific disease)
Wheelchair
Wigs (hair loss due to disease)

Ineligible Expenses
The IRS does not allow the following expenses to be reimbursed. This list is not meant to be all-inclusive.

Contact Lens or Eyeglass Insurance
Cosmetic Surgery/Procedures
Dancing/Exercise/Fitness Programs
Diaper Service
Electrolysis
Personal Trainers or Exercise Equipment
Hair Loss Medication
Hair Transplant
Health Club Dues
Insurance Premiums and Interest
Long Term Care Premiums
Marriage Counseling
Maternity Clothes
Vitamins or Nutritional Supplements
Swimming Lessons
Teeth Whitening/Bleaching
Tuition fees and deposits
Residential nursing homes
Piano, dancing, art, ballet lessons, etc.
Health care expenses for a dependent

Internal Revenue Code Section 213d governs the eligible expenses. IRS Publication 502 is written to help taxpayers determine what qualified expenses can be deducted on their income tax returns. They should not be used as the sole determinant for what is reimbursable under the Plan.

Expansion of Qualifying Medical Expenses: Over the Counter Medicines/Drugs and Menstrual Care Products

Pursuant to the Coronavirus Aid, Relief and Economic Security Act (known as the "CARES" Act), the type of qualifying medical expenses that may be purchased with funds or seek reimbursement from an HRA include 1) over-the-counter (OTC) medicines and drugs without a prescription and 2) menstrual care products (defined as tampons, pads, liners, cups, sponges and similar products used by the individual with respect to menstruation).

ARTICLE III: TERMINATION OF COVERAGE

SECTION 3.01 – TERMINATION OF COVERAGE - ACTIVE EMPLOYEE

Coverage shall continue until the end of the month in which the balance in the Reserve Account falls below 120 hours after the 120 hour deduction has been made for that month's coverage or on the date the Plan terminates, whichever occurs first, except as set forth in Plan Section 5.12.

If the Participant performs any type of work in the electrical industry as an employee, supervisor, or independent contractor or any other position, with or without compensation, for an Employer that is not a contributing Employer to this Plan, you are no longer eligible for coverage under the Plan (as an Active Employee or any other category). Moreover, loss of coverage for this reason is not a qualifying event under COBRA.

SECTION 3.02 – TERMINATION OF COVERAGES - EARLY RETIRED EMPLOYEE

If an Employee is an Early Retired Employee (between ages 55 and 62), coverage under this Plan shall terminate permanently on the last day of the last month for which the required self-contribution was not timely received by the Trust Fund Office. To become covered again after such termination, the Employee must re-qualify as an Active Employee. On the Retired Employee's 62nd birthday, unless he qualifies for continued coverage as a regular Retired Employee, all coverage shall automatically terminate, except as set forth in Section 5.12.

Coverage as an early Retired Employee shall terminate on the earlier of the date the Plan no longer provides such retiree coverage or the end of the month for which the last payment is made for the coverage.

If the Participant performs any type of work in the electrical industry as an employee, supervisor, or independent contractor or any other position, with or without compensation, for an Employer that is not a contributing Employer to this Plan. You are no longer eligible for coverage as a Retired Employee. Moreover, loss of coverage for this reason is not a qualifying event under COBRA.

SECTION 3.03 – TERMINATION OF COVERAGES - RETIRED EMPLOYEE

If an Employee is a Retired Employee, coverage shall terminate on the date the Plan no longer provides such retiree coverage or the end of the month the Board of Trustees determines that benefits terminate or the end of the month for which the last payment is made for the coverage, whichever occurs first.

If the Participant performs any type of work in the electrical industry as an employee, supervisor, or independent contractor or any other position, with or without compensation, for an Employer that is not a contributing Employer to this Plan. You are no longer eligible for coverage as a Retired Employee. Moreover, loss of coverage for this reason is not a qualifying event under COBRA.

SECTION 3.04 – TERMINATION OF COVERAGE - NON-COLLECTIVE BARGAINING EMPLOYEE

Coverage shall remain in force until the end of the last month for which the subscribing Employer has made the required payment when due. Payments received by the Trust Fund Office after the delinquency date may be accepted if the Board of Trustees finds failure to contribute was due to extenuating circumstances, except as set forth in Plan Section 5.12.

Coverage shall not continue beyond the earlier of the date on which the Plan no longer provides such coverage or on the date on which the Employer ceases to be a subscribing Employer.

If a subscribing Employer unilaterally terminates coverage or loses coverage for non-payment of benefits that Employer may not again be considered eligible for coverage until eighteen consecutive months has passed.

SECTION 3.05 – TERMINATION OF COVERAGE (DEPENDENTS)

Dependents' coverage shall remain in force until the date that person no longer qualifies as an eligible Dependent, but it shall not continue beyond the date an Employee's coverage terminates, except as set forth in Article IV below (COBRA) or Plan Section 5.12.

Special Enrollment Rights under HIPAA

If you decline enrollment for yourself or your Dependents (including your spouse) because of other health insurance coverage, you may in the future be able to enroll yourself or your Dependents in this Plan, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new Dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your Dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption, or placement for adoption.

SECTION 3.06 – MEDICARE

Medical coverage shall not terminate for a Covered Person who is a retiree or a Dependent of a retiree when he or she becomes eligible for Medicare.

SECTION 3.07 – CANCELLATION OF PARTICIPATION AND RESERVE ACCOUNT

Circumstances requiring immediate cancellation of participation, including cancellation of Reserve Account: A covered Participant shall have his coverage cancelled and his bank of Reserve Hours immediately reduced to zero under the following circumstances:

1. If the Participant fails to report the existence of other group health coverage on any benefit claim form submitted under this Plan, as set forth in the Coordination of Benefits (COB) section.

2. If the Participant knowingly permits a contributing Employer to contribute to this Fund on less than all of the hours that the individual worked for such Employer, including all overtime hours.

   If the Participant performs any type of work in the electrical industry as an employee, supervisor, or independent contractor or any other position, with or without compensation, for an Employer that is not a contributing Employer to this Plan.

Coverage also terminates as of the date a Participant enters into full-time active duty with the armed forces of the United States and/or any other country (subject to the requirements of the Uniformed Services Employment and Re-Employment Rights Act.)

ARTICLE IV: CONTINUATION OF COVERAGE - COBRA

SECTION 4.01 – COBRA COVERAGE

A federal law, known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires that group health plans offer covered Employees and their dependents the opportunity to elect to pay for a temporary extension of health coverage (called "COBRA Continuation Coverage") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive this continuation coverage the Employee, spouse and/or dependent(s) must make timely monthly payments directly to the Plan.

When you no longer have sufficient hours in your Reserve Hour Bank, your COBRA coverage will run concurrently with any continuation of coverage offered by the Plan or the Trustees. **In other words, your COBRA extension period is reduced by the number of months under Subsidized Self-Pay coverage.**

Even if you do not elect COBRA continuation coverage, your Spouse and each of your eligible Dependents have a separate right to elect it. You, your Spouse and your eligible Dependents should all read this section of your benefit booklet.

Coverage under the Plan may be extended by making self-payments for specified periods. To maintain continued coverage, an Employee whose coverage has terminated because of a qualifying event as described in Section 4.03 may elect to continue coverage as set forth below.

SECTION 4.02 – CONTINUED COVERAGE

The Covered Person's continued coverage shall include only health benefits, either medical coverage only, or medical plus any dental, vision or prescription drug coverages.

SECTION 4.03 – QUALIFYING EVENTS

Continued coverage is required if one of the following qualifying events results in the Covered Person's coverage ending:

1. the Employee's death;
2. the termination of employment for a reason other than gross misconduct;
3. reduction of the Participant's work hours;
4. divorce or legal separation from spouse;
5. the Participant becoming entitled to benefits under Medicare; or
6. a Dependent child ceasing to be eligible as a Dependent under this Plan.

SECTION 4.04 – NOTIFICATION REQUIREMENTS

1. Election of COBRA Coverage

The Trust Fund Office will provide you with COBRA coverage and enrollment information within 45 days of receiving written notification of a qualifying event entitling you and/or your Dependent(s) to COBRA coverage. You and/or your Dependent(s) must elect COBRA coverage within 60 days after your Plan coverage ends or the date you receive the election form, whichever is later. Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA coverage is first elected. After this first premium, there is a 30-day grace period for making future COBRA payments. No benefit claim will be honored unless the Trust Fund Office has received the required payment for the period in which the claim was incurred. **If you elect COBRA, you will be entitled to the same health coverage that is provided to active employees and Dependents in the Plan. Therefore, if there are any changes to the Plan for active employees, your benefits will also change.**

Active Subsidized Self-Pay For Coverage. If your loss of coverage is due to a reduction in hours of termination of employment and you were eligible for coverage under the Subsidized Self-Pay plan provisions prior to your loss of coverage, you may be eligible to make self-payments to the Plan at a rate determined by the Board of Trustees. Please note the time period for your COBRA continuation coverage will be reduced by your months of Active Subsidized Self-Pay.

You have the option of electing one of the following COBRA Plans and paying the designated premiums:

a. **CORE COVERAGE** - Provides coverage for medical and prescription drugs only.

b. **CORE AND NON CORE COVERAGE** - Provides coverage for medical, prescription drugs, dental, orthodontia, vision and hearing aid.

The premiums for COBRA will increase each year. You have the option of changing Medical Plans while covered under COBRA, subject to residing within the HMO's service area, and remittance of the applicable COBRA payment for the Medical Plan you have elected.

California Insurance Marketplace (California Exchange)

In addition to COBRA continuation coverage, there may be other options for you and your family. The California Insurance Marketplace (California Exchange) offers many health plans to choose from. Open enrollments will be held generally from October 15 through December 15 for coverage effective the following year. After Open Enrollment ends, you may have special enrollment rights under certain circumstances. More information is available from the California Exchange website at www.coveredca.com. Also, you might be eligible for a tax credit that lowers your monthly premium if you are not eligible for coverage through the Plan.

Note: If you decide to enroll in COBRA coverage and then drop your COBRA coverage, you can only enroll in Exchange coverage during the Exchange Open Enrollment Period, effective January 1.

2. **Participant Notice to the Plan.** A Covered Person who wants continued coverage because of a qualifying event shall notify the Fund Office of a change in family status within 60 days after it occurs. A change in family status means: (a) divorce or legal separation from his spouse; or (b) a child's ceasing to be eligible as a Dependent under this Plan.

Failure to give timely notification will end your eligibility for continued Coverage due to the change in family status.

The Employee is required to immediately notify the Plan Office of any qualifying event but in any event within 30 days after the change occurs.

Within 14 days after the Covered Person notifies the Plan Fund Office of a qualifying event, the Trust office shall notify a Covered Person who is eligible for continued coverage of the following:

1. the right of continued coverage;
2. the amount that shall be paid each month to continue the coverage; and
3. how, when and to whom the monthly payments shall be made.

Notice that is given to a spouse is deemed to be given to each child who lives with the spouse and whose coverage would end due to the same qualifying event.

SECTION 4.05 – REQUEST FOR CONTINUED COVERAGE

When a Covered Person has been given notice of the right to continued coverage, the continued coverage shall be requested in writing within 60 days after:

1. the date of the notice of the right to continued coverage; or
2. the date coverage under this Plan otherwise would end, whichever is later.

A request for continued coverage will be deemed to include Covered Dependents unless requested that it not include them. A request by a spouse may include Covered Dependents who live with the spouse. If you do not elect COBRA Continuation Coverage, each of your dependents may independently elect such coverage on behalf of himself or herself and pay the required premiums.

SECTION 4.06 – PAYMENTS FOR CONTINUED COVERAGE

The Covered Person's first payment shall be for the period of continued coverage beginning on the first day following the date of the qualifying event and ending on the last day of the month following the date on which the written request for the continued coverage is made. This payment shall be due no later than the 45th day after the date on which the Covered Person's written request for continued coverage is given to the Trust Office, or, if mailed, on the 45th day after the date the written request is postmarked.

Thereafter, the Covered Person shall pay monthly **in advance** for the continued coverage. The monthly payment shall be no more than 102% of the current full monthly cost for the coverage under this Plan except that during the additional 11 months of continued coverage provided for a disabled Employee, the monthly payments shall be no more than 150% of the current full monthly cost for the coverage.

SECTION 4.07 – COBRA AND MEDICARE

If a covered Employee has a Qualifying Event due to termination of employment or reduction in work hours, and the Qualifying Event occurs less than 18 months after the date the Employee became entitled to Medicare, then the maximum COBRA Coverage period for the Employee's Dependents is extended to the last day of the 36-month period beginning on the date the Employee became entitled to Medicare, while the maximum period of maximum COBRA Coverage period for the covered Employee is 18 months from the Qualifying Event. If a covered Employee has a Qualifying Event due to termination of employment or reduction in work hours and, after the Employee has elected COBRA Coverage and during the first 18 months of such coverage, the Employee first becomes entitled to Medicare, the Employee's COBRA Coverage will end.

COBRA Coverage with respect to the covered Employee's Dependents who have elected COBRA Coverage will not be terminated due to the Employee's entitlement to Medicare and may continue through the remainder of the 18-month maximum coverage period. For purposes of this article, "entitled to Medicare" means (i) enrollment in Medicare Parts A or B or (ii) having ESRD and (a) having applied for Medicare Part A, (b) having satisfied any waiting period requirement and (c) being either (1) insured under Social Security, (2) entitled to retirement benefits under Social Security or (3) a spouse or dependent of an individual satisfying either (1) or (2).

SECTION 4.08 – TERMINATION OF CONTINUED COVERAGE

Except as provided below, eligibility for continued coverage shall end on the earlier of the following:

1. **COBRA TIME PERIOD ENDS.** The end of the 18 month period following the date of the qualifying event, if the event is the termination of employment or reduction of work hours unless the reason is for gross misconduct;

COBRA TIME PERIOD ENDS – 36 months situation – Spouse or Dependents. The end of the 36 month period following the date of any of the following qualifying events: (a) death, (b) divorce or legal separation from spouse, (c) becoming entitled to benefits under Medicare, or (d) a child ceasing to be eligible as a Dependent under this Plan;

2. **FAILURE TO TIMELY PAY PREMIUM.** The end of the last month for which a Covered Person has made the required payment for continued coverage; the date on which any payment for continued coverage is not made in a timely manner. A payment shall be considered received in a timely manner if it is received within 31 days after becoming due;

3. **COVERAGE UNDER ANOTHER PLAN.** The date a Covered Person becomes covered under another group health plan;

4. **ENTITLED TO MEDICARE.** The date a Covered Person becomes entitled to benefits under Medicare after having elected COBRA;

5. **NO ACTIVE PLAN COVERAGE.** The date on which the Plan ends coverage for the class of Covered Persons to which class a person receiving continued coverage belonged to before his continued coverage began.

6. **EMPLOYER NO LONGER CONTRIBUTES.** The date your employer who contributed on your behalf ceases to be a contributing Employer.

SECTION 4.09 – EXCEPTIONS TO TERMINATION OF CONTINUED COVERAGE

Section 4.07 shall not be applicable in the following situations:

1. **If the Covered Person Received a Social Security Disability Award.** For an additional premium equal to 150% of the cost of coverage, the maximum period of continued coverage shall be extended beyond 18 months for an additional 11 months if (a) the Covered Person is determined by the Social Security Administration to have been disabled within 60 days of the date of the qualifying event or the loss of coverage, (b) the Covered Person furnishes notice of Social Security's determination of disability to the Trust office before the end of the initial 18 month period of continued coverage, and (c) the Covered Person remains disabled until the end of the combined 29 month period of continued coverage. The continued coverage shall stop, however, at the end of the month following any one of the additional 11 months during which the Social Security Administration makes a final determination that the Covered Person is no longer disabled.

2. **If Another Qualifying Event Occurs.** If a subsequent qualifying event occurs with a maximum period of 36 months of continued coverage while a Covered Person and his Covered Dependents are receiving 18 months of continued coverage due to an initial qualifying event, the maximum period of continued coverage for Dependents shall become 36 months from the date of the initial qualifying event.

3. **If Medicare is Not a Qualifying Event.** If a Covered Person becomes entitled to benefits under Medicare, but that event is not a qualifying event because coverage does not end for that reason, and, subsequently, a qualifying event occurs entitling the Covered Person and his Covered Dependents to 18 months of continued coverage, the maximum period of continued coverage for Dependents shall be a period of 36 months from the date the Employee became entitled to benefits under Medicare.

4. **Multiple Qualifying Events.** An 18-month period of COBRA continuation coverage may be extended for up to 36 months for your spouse or Dependent child if a second qualifying event occurs (such as your death or divorce, or your child no longer qualifies for coverage, or you become entitled to Medicare) within the first 18 month period. In no event, however, will such coverage extend beyond 36 months from the date coverage was first lost due to the initial qualifying event.

EXAMPLE: A PARTICIPANT'S SPOUSE IS ON COBRA CONTINUATION COVERAGE DUE TO THE PARTICIPANT'S TERMINATION OF EMPLOYMENT. THE PARTICIPANT PASSES AWAY AFTER 12 MONTHS OF COVERAGE DURING THE 18 MONTH PERIOD. HIS OR HER DEATH IS A SECOND "QUALIFYING EVENT", WHICH ENTITLES THE SPOUSE TO THE REMAINING BALANCE OF 24 MONTHS (36 MONTH MAXIMUM MINUS THE 12 MONTHS THAT HAS ALREADY BEEN COVERED).

ARTICLE V: GENERAL PROVISIONS

SECTION 5.01 – NO ASSIGNMENT OF BENEFITS

The benefits payable hereunder shall not be subject to any manner of anticipation, alienation, sale, transfer, assignment, pledge or garnishment.

SECTION 5.02 – TIME TO FILE CLAIMS

Benefits shall be paid by the Plan only if notice of a claim is made within one hundred eighty (180) days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as required by the Board of Trustees. Any submission of claims later than one hundred and eighty (180) days is subject to the approval of the Board of Trustees, but in no event shall claims be considered for payment later than twelve (12) months from the date on which covered charges were incurred.

SECTION 5.03 – INCOMPETENCE OR INCAPACITY

If the Plan determines that the Covered Person is incompetent or incapable of executing a valid document and no guardian has been appointed, or the Covered Person has not provided the Plan with an address at which the person can be located for payment, the Plan may, during the lifetime of the Covered Person pay any amount otherwise payable to the Covered Person, to the spouse, or relative by blood of the Covered Person, or to any other person or institution determined by the Plan to be equitably entitled thereto; or in the case of the death of the Covered Person before all amounts payable have been paid, the Plan may pay any such amount to one or more of the following surviving relatives of the Covered Person: Lawful spouse, child or children, mother, father, brothers or sisters, or to the Covered Person's estate, as the Board of Trustees, in its sole discretion, may designate. Any payment in accordance with this provision shall discharge the Plan and the Trustees hereunder to the extent of such payment.

SECTION 5.04 – NO RIGHT TO BENEFITS

No Covered Person or other beneficiary shall have any right or claim to benefits from the Plan, except as specified herein. Any dispute as to eligibility, type, amount or duration of benefits under this Plan or any amendment or modification thereto shall be resolved by the Board of Trustees. No action may be brought for benefits provided by this Plan or any amendment or modification thereof, or to enforce any right thereunder, until after the claim has been submitted to and determined by the Board of Trustees. No such action may be brought unless brought within one year after date of such decision. The decision of the Board of Trustees shall be final and binding on all parties.

SECTION 5.05 – WORKERS COMPENSATION INSURANCE

The benefits provided by the Plan are not in lieu of and do not affect any requirement for coverage by Workers' Compensation Insurance laws or similar legislation

SECTION 5.06 – CONTROL DOCUMENTS

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

SECTION 5.07 – AVAILABLE ASSETS FOR BENEFITS

The benefits provided by this Plan 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 the 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 this Plan 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 the 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 person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

SECTION 5.08 – FUND MAY SELECT PHYSICIAN OR OTHER MEDICAL PROVIDER

The Fund, at its own expense, shall have the right and opportunity to have a physician or other medical provider of its choice examine the Covered Person when and so often as it may reasonably require related to any claim and/or issue.

SECTION 5.09 – TRUSTEE RIGHTS

To carry out its obligation to maintain, within the limits of the funds available, a sound economic program dedicated to providing the benefits for Covered Persons, the Board of Trustees expressly reserves the right, in its sole discretion:

1. to terminate or amend either the amount or conditions with respect to any benefits or provisions of the Plan even though such termination or amendment affects the claims in process and/or expenses already incurred; or

2. to alter or postpone the method of payment of any benefit; or

3. to amend any provision of this Plan Document.

SECTION 5.10 – THIRD PARTY RECOVERY

If the Covered Person is injured through the act or omission of another party, Plan benefits are available provided:

1. The Plan does not cover any illness, injury, disease or other condition for which a third party may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

   You are required to notify the Plan Office if any claims you incur under the Plan are the result of an accident, injury, disease or other condition for which a third party is OR MAY BE liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that third party.

   Charges incurred by a Participant or dependent for which a Third Party is responsible are not covered charges under any benefits provided in this Plan; however, payments may be advanced to an otherwise eligible participant or beneficiary, if the conditions of this section are met.

2. The Covered Person agrees to pay to the Plan immediately any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage or other insurance including the Participant's own or family insurance coverage.) arising out of any claims for damages by the individual or his heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the third party may be responsible. Any Covered Person who accepts payments from the Plan agrees that by doing so he is making a present assignment of his rights against such third party to the extent of the payments made by the Plan. The Plan may require that any Covered Person execute an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require. Any Covered Person who refuses to execute an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved. Any Covered Person who receives benefits and later fails to reimburse the Plan as set forth above shall be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the Covered Person has failed to reimburse, including reasonable interest on such unpaid funds.

3. By accepting payments from the Plan, any Covered Person agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the Covered Person's own carrier for uninsured motorist coverage. A lien shall exist in favor of the Plan upon all sums of money recovered by the Covered Person against the third party. The lien may be filed with the third party, the third party's agents, or the court. The Covered Person shall do nothing to prejudice the Plan's rights as described above without the Plan's written consent.

4. If the Covered Person settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Covered Person shall receive no further benefits from the Trust in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Trust. **The Plan may offset any future claims incurred by the Participant and/or his or her family members against amounts owed to the Plan.**

SECTION 5.11 – ERISA

This Plan of benefits is an "Employee Benefit Plan" under the Employee Retirement Income Security Act of 1974 as amended ("ERISA").

SECTION 5.12 – PARTICIPANT ON ACTIVE MILITARY SERVICE:

1. **Military Duty.** If a Participant is called to active military duty for a period of 30 days or longer, the Participant may elect either of the following options:

a. to have his Reserve Hour Bank frozen as of the first day of the month following the commencement of active service, which will terminate all eligibility for the Employee and any dependents; or

b. to continue the eligibility of the Employee's dependents using the Employee's Reserve Hour Bank, until it is depleted (and then be eligible to pay a premium for COBRA).

2. **Eligibility Rules for USERRA.** To qualify for re-employment rights under the Uniformed Service Employees Reemployment Rights Act ("USERRA"), including certain limited health care benefits (summarized below), a Covered Employee must meet the following requirements:

a. **Purpose of Leave.** The employee had to leave civilian employment for the purpose of entering a "uniformed service." Uniformed services includes the Army, Navy, Air Force, Marine Corp, Coast Guard, National Guard (full time duty), Commissioned Corps of Public Health Service and anyone else designated as Covered by the President of the United States during time of war or National Emergency.

b. **Employee Provide Prior Notice of Service.** An employee leaving for uniformed service has to provide prior notice that his or her absence will be due to uniformed service. Written notice is not required. You are strongly urged to notify the Union Dispatch Office so that the uniformed service may be noted on the dispatch rolls, your employer, and the Plan Office so the Plan is aware of your situation.

c. **Assert Military Rights for no More than Five Years (with certain exceptions).** You may assert USERRA benefits for military absence not to exceed five years. There are limited exceptions to the five year rule so if you are close to that period, you may contact the Plan Office to determine if your situation may meet an exception to the five year rule.

d. **Employee Must be Honorably Discharged from Service.** The employee must have been honorably discharged from the military service.

e. **Return to Covered Employment within a Specified Period.** You must return to your same employer or another employer that contributes to the Plan within a specified period of time, depending upon the length of time you are absent for military service. The rules for return to employment are:

i. Service of Less than 31 Days. If your period of military service is less than 31 days, you must be available for Covered Employment on the next calendar day (so long as you had at eight hours rest after returning home by normal transportation methods) following the end of service.

ii. Service of More than 30 and Less than 181 Days. If your military service lasts longer than 30 days but less than 181 days, you must be available for Covered Employment no later than 14 days after completion of military service.

iii. Service of More than 180 Days. If your leave from Covered Employment for military service exceeds 180 days, you must be available for Covered Employment no later than 90 days after you have completed your military service.

3. Right to Certain Health Care Benefits Under the Plan

a. **Less than 31 Days of Service-One Month of Free Coverage.** If you are absent from Covered Employment because of active military service for less than 31 days, you may elect to continue your coverage with this Plan at the expense of the Plan.

b. **Absent for More than 30 Days.** If you are absent from Covered Employment as a result of military service for more than 30 days, you may elect to purchase COBRA-like coverage for up to 24 months (the first month of which is free). After that first 30 days you will be required to pay a premium which is 102% of the Plan's cost of the coverage. Typical rights under COBRA are for 18 months, rather than the longer 24 month periods for veterans. USERRA's continuation requirements are similar but not identical to COBRA's requirements. Your absence for service in the uniformed services will trigger rights under both statutes, and you are entitled to protection under the law that provides the most favorable benefit.

c. **Hour Bank Frozen if so Requested.** Unless you request otherwise, your Hour Bank (Reserve Account) under the Plan will be frozen effective with the first of the month following the month that eligibility will be provided from your last hours of employment before entering the service. For example, if you last worked in January, you will have your Hour Bank frozen as of March, with coverage for April provided at the Plan's expense. If you wish to continue coverage for up to the additional 23 months after April, you may then do so by electing and paying COBRA-like payments to the Plan Office. After you return to Covered Employment (with proper notice and documentation), your Hour Bank will be reinstated in accordance with the Plan rules.

d. **Twenty Four Months of Continuation Coverage.** The Participant and/or any dependents will be eligible to pay for Continuation Coverage for up to 24 consecutive months. Coverage under the Participant's Hour Bank will recommence after discharge from active military duty if the Employee returns to work for a contributing Employer or becomes available to work for a contributing Employer as shown by registration on the Union's out-of-work list provided the Employee returns to work or registers within 90 days of discharge.

SECTION 5.13 – PRIOR AUTHORIZATION: ANTHEM BLUE CROSS

The Plan continues to require prior authorization for inpatient hospital stays, hospital outpatient surgery and outpatient surgery at an ambulatory surgical center, and for other procedures. There could, in limited situations, be procedures or treatment that does not require prior authorization. The Plan will follow the Standard Prior Authorization Requirements of Anthem Blue Cross, as they may be amended. **Participants should contact the Trust Fund Office in advance for a determination whether prior authorization is required for the procedure or treatment.** The Anthem Blue Cross Group number is 277790M001.

COST CONTAINMENT – Provided by Anthem Blue Cross

Benefits are provided only for **MEDICALLY NECESSARY** and appropriate services. Cost containment provides you with valuable information so that unexpected out-of-pocket costs can be avoided.

MEDICALLY NECESSARY

Medically Necessary means that the treatment must be ordered by a Physician or Other Accredited Provider to diagnose or treat an Injury or Illness, and be:

(a) generally recognized as effective and essential to the treatment of the Injury or Illness for which it is ordered;
(b) appropriate for the symptoms and consistent with the diagnosis; and
(c) the appropriate level of care, and which (i) is provided in the most appropriate setting, based on the diagnosis and condition, (ii) could not have been omitted without an adverse effect on the Covered Individual's condition or the quality of medical care, (iii) is based on generally recognized and accepted standards of medical practice in the United States, and (iv) is neither:

    (1) Experimental or Not Generally Accepted or primarily limited to research in its application to the Injury or Illness;
    (2) primarily for scholastic, educational, vocational or developmental training;
    (3) primarily for the comfort, convenience or administrative ease of the Covered Individual, Physician or other Accredited Provider or member of his or her family or caretaker; nor
    (4) Custodial Care.

The Plan may rely on Anthem Blue Cross and/or an independent medical reviewer to determine if treatment is Medically Necessary. The fact that a Physician orders treatment is not, by itself, sufficient to make it Medically Necessary.

Cost Containment is a Utilization Review Program that includes pre-authorization for all inpatient hospital stays, hospital outpatient surgery and outpatient surgery at an ambulatory surgical center. It also includes concurrent and retrospective reviews and personal case management. The personal case management helps you coordinate and manage long-term intensive medical care.

No benefits are payable, however, unless your coverage is in force at the time services are rendered, and the payment of benefits is subject to all the terms and conditions of this Plan.

Important: Cost containment requirements may not apply when coverage under this Plan is secondary to another plan providing benefits for you or your family members.

A. **UTILIZATION REVIEW PROGRAM –** The utilization review program evaluates the medical necessity and appropriateness of care and the setting in which care is provided. You and your physician are advised if Anthem Blue Cross has determined that services can be safely provided in an outpatient setting, or if an inpatient stay is recommended. Services that are medically necessary and appropriate are certified by Anthem Blue Cross and monitored so that you know when it is no longer medically necessary and appropriate to continue those services.

B. **UTILIZATION REVIEW REQUIREMENTS –** Utilization reviews are conducted by Anthem Blue Cross for the following services:

- All inpatient hospital stays.
- All hospital outpatient surgery.
- Outpatient surgery at an ambulatory surgical center.

There are three stages of utilization review:

1. Pre-service review determines the medical necessity and appropriateness of scheduled, non-emergency hospital admissions and outpatient surgeries done in a hospital or in an ambulatory surgical center.

2. Concurrent review determines whether services are medically necessary and appropriate when pre-service review is not required or has not been performed as required.

3. Retrospective review is performed to review services that have already been provided in cases when Anthem Blue Cross was not notified and therefore was unable to perform a pre-service or concurrent review, or in order to evaluate and audit medical documentation subsequent to services being provided. Retrospective review may also be performed for services that continued longer than originally certified.

C. **EFFECT ON BENEFITS –** In order for the full benefits of this Plan to be payable, the following criteria must be met:

1. The appropriate utilization reviews must be performed in accordance with this Plan. When pre-service review is not performed as required for a hospital admission, outpatient surgery done in the hospital or in an ambulatory surgical center, the benefits to which you would have been otherwise entitled will be subject to retroactive review and possible denial.

2. The services must be medically necessary and appropriate. Inpatient hospital benefits will be provided only when an inpatient stay is medically necessary and appropriate. If you proceed with any services that have been determined to be not medically necessary and appropriate at any stage of the utilization review process, benefits will not be provided for those services.

3. Services that have not been reviewed previously by Anthem Blue Cross will be reviewed when the bill is submitted for benefit payment. If that review results in the determination that part or all of the services were not medically necessary and appropriate, benefits will not be paid for those services.

D. **HOW TO OBTAIN UTILIZATION REVIEWS –** It is always your responsibility to confirm that the review has been performed.

1. For all scheduled services that are subject to utilization review, you or your physician must initiate the pre-service review at least three working days prior to when you are scheduled to receive services.

2. You must tell your physician that this Plan requires pre-service review. Physicians who are participating providers will initiate the review on your behalf. A non-participating provider may initiate the review for you, or you may call Anthem by referring to the number printed on the back of your ID card, or at (800) 274-7767. For assistance, contact the Trust Fund Office at (408) 588-3753.

3. If you do not receive the certified service within 60 days of the certification, or if the nature of the service changes, a new pre-service review must be obtained.

4. Anthem Blue Cross will certify services that it determines are medically necessary and appropriate. For inpatient hospital stays, Anthem Blue Cross will, if appropriate, certify a specific length of stay for approved services. You, your physician and the provider of the service will receive a notice showing this information.

5. If Anthem Blue Cross determines that the proposed services are not medically necessary and appropriate, your physician will not be notified immediately. Written notice will be sent to you and the provider of the service and will explain the appeal process.

E. CONCURRENT REVIEWS

1. If pre-service review was not performed, you, your physician or the provider of the service must contact Anthem Blue Cross for concurrent review. For an emergency admission or procedure, Anthem Blue Cross must be notified within one working day of the admission for procedure, unless extraordinary circumstances prevent such notification within that time period.

2. When participating, providers have been informed of your need for utilization review, they will initiate the review on your behalf. You may ask a non-participating provider to call Blue Cross or you may call them directly. Anthem Blue Cross toll-free number is printed on your identification card.

3. If Anthem Blue Cross determines that the service is medically necessary and appropriate, Blue Cross will, depending upon the type of treatment or procedure, certify the service for a period of time that is medically appropriate. Anthem Blue Cross will also determine the medically appropriate setting.

4. If Anthem Blue Cross determines that the service is not medically necessary and appropriate, you and your physician will receive written notice.

F. EXTRAORDINARY CIRCUMSTANCES

In determining “extraordinary circumstances,” Anthem Blue Cross may take into account whether your condition was severe enough to prevent you from notifying Anthem Blue Cross or whether or not a member of your family was available to notify Anthem Blue Cross for you. You may have to prove that such “extraordinary circumstances” were present at the time of the emergency.

G. RETROSPECTIVE REVIEWS

Retrospective review is performed when Anthem Blue Cross has not been notified of the service you received and as a result has been unable to perform the appropriate review prior to your discharge from the hospital or completion of outpatient treatment. It is also performed when pre-service or concurrent review has been done, but services continue longer than originally certified. It may also be performed for the evaluation and audit of medical documentation after services have been provided, whether or not pre-services or concurrent review was performed. Such services which have been retroactively determined to not be medically necessary and appropriate will be retrospectively denied certification.

H. CASE MANAGEMENT

In some instances, a patient's needs may be met as well or better by offering an alternative to an acute care hospital confinement. Such plans could include home, hospice or convalescent nursing home care. In appropriate cases, working with the patient's own physician, the Case Management program assesses that alternative care is suitable for the individual patient and that the health care services are coordinated and carried out in a manner that ensures continuity and quality of care.

The Plan will pay benefits only on expenses incurred for alternative treatment plans that have been arranged and pre-approved by Anthem Blue Cross.

SECTION 5.14 – ADMINISTRATION AND OPERATION

1. **Administration Responsibilities.** The Board of Trustees of the Plan is the named fiduciary with the authority to control and manage the operation and administration of the Plan. The Board shall make such rules, interpretations and computations and take such other actions to administer the Plan as the Board, in its sole discretion, may deem appropriate. The rules, interpretations, computations and actions of the Board shall be binding and conclusive on all persons.

2. **Standards of Interpretation.** The Board of Trustees, and/or persons appointed by the Board, shall have the full discretionary authority to determine eligibility for benefits and to construe the terms of this Plan and any regulations and rules adopted by the Board.

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

4. **Proof of Eligibility.** The Board of Trustees may withhold the payment of benefits unless and until the Participant has submitted proof of eligibility for himself or herself and/or his or her eligible dependents. Proof of eligibility shall be submitted on forms and with documents required by the Board of Trustees.

SECTION 5.15 – EXTENSION OF BENEFITS

If a covered Employee or eligible Dependent is an Inpatient in a hospital or convalescent hospital on the date his or her medical coverage terminates, the medical benefits shall continue to be payable during that confinement. This extension shall terminate when the confinement terminates, but in no event shall it continue for more than 12 months, or beyond the date the Plan terminates, whichever is sooner.

SECTION 5.16 – ADDITIONAL ACCIDENT BENEFIT

Charges made by a covered physician or other medical service provider for treatment commencing within 90 days immediately following a non-occupational injury effected through external or accidental means, up to the amount shown in the "SCHEDULE OF BENEFITS" is payable in full for covered charges incurred. The Maximum Benefit shall be for each accident and the calendar year deductible does not apply.

SECTION 5.17 – QUALIFIED MEDICAL CHILD SUPPORT ORDERS

The Plan will extend benefits to a Participant's non-custodial child, as required by any qualified medical child support order ("QMCSO") under ERISA §609(a), including a National Medical Support Notice described in ERISA Regulation §2590.609-2. The Plan has procedures for determining whether an order qualifies as a QMCSO, which any Covered Individual can obtain from the Plan Office.

SECTION 5.18 – SECOND SURGICAL OPINION BENEFIT

A. **SECOND OPINIONS.** Charges incurred by a Covered Person for consultation of a legally qualified physician for a second surgical opinion as to the need for a surgical procedure of a non-emergency nature resulting from non-occupational injury or sickness, otherwise covered under and subject to the provisions of this Plan. The Plan shall reimburse such Covered Person 100% of the first $100.00 of charges incurred for such consultation, including any necessary x-ray and laboratory examinations recommended by such legally qualified physician. For charges incurred in excess of $100, reimbursement to the person shall be subject to the Network Allowance, Coinsurance Percentage and Deductible Amount.

If the second surgical opinion does not confirm the need for surgery and a Covered Person consults another legally qualified physician for a third opinion, the Plan shall reimburse such person, subject to the limitations of this provision, 100% of the first $100.00 of charges incurred for such consultation, including any necessary x-ray and laboratory examination recommended by such legally qualified physician. For charges incurred in excess of $100.00, reimbursement to the person shall be subject to the Network Allowance Coinsurance Percentage and Deductible Amount.

For the purpose of this Article, a legally qualified physician means a physician who is Board certified in the field of the proposed surgery or in the field of medical specialization concerned with the condition involved.

B. **LIMITATIONS OF SECOND AND THIRD OPINIONS. No payment shall be made:**

1. for surgery consultation made by a physician who is not Board certified in the field of medical specialization concerned with the proposed surgery,

2. for more than two surgery consultations made in connection with the proposed surgery,

3. for any x-ray and laboratory charges other than charges made in connection with the surgical consultation,

4. unless the Covered Person is examined in person by the physician rendering the second or third surgical opinion and a written report is submitted to the Trust,

5. if the physician who rendered the second or third surgical opinion also performs the surgery, or who has a financial interest in the outcome (for or against surgery) of the recommendation,

6. for any surgical consultation fees incurred for:

    a. Dental work or treatment.

    b. Cosmetic surgery, except as required because of accidental bodily injury occurring while covered hereunder. "Cosmetic surgery" shall not include reconstructive surgery when service is incidental to or follows surgery resulting from trauma, infection or other disease of the involved part, or reconstructive surgery because of congenital disease or anomaly of an eligible Dependent child which has resulted in a functional defect.

    c. Occupational Disease. “Occupational disease" means a disease for which such Covered Person with regard to whom a claim is submitted, is entitled to benefits under applicable Workmen's Compensation Law, Occupational Disease Law, or similar legislation.

    d. Accidental bodily injuries arising out of and in the course of such Covered Person’s employment.

SECTION 5.19 – TEMPORARY EMERGENCY EXTENSION RULES DURING PUBLIC HEALTH EMERGENCY.

Effective immediately, joint IRS and DOL emergency regulation requires that the Plan (and insurance carriers and health maintenance organizations} must disregard the period from March 1, 2020 until sixty (60) days after the announced end of the National Emergency or another date determined by the agencies in a future notice (referred to as the "Outbreak Period") for all Plan Participants, beneficiaries, qualified beneficiaries, or claimants wherever located in determining the following periods and dates:

1. **COBRA Qualifying Event Notice.** For Qualifying Events or receipts of the notice of COBRA continuation coverage occurring on or after March 1, 2020, the 60-day period to give a Qualifying Event Notice will be temporarily tolled until 60 days after the end of the Outbreak Period (which is an unknown date at this stage);

2. **COBRA Premium Payments (For Initial Payment and Ongoing Monthly Payments).** If COBRA coverage is first elected during the Outbreak Period, all monthly premium payments for all months for which coverage is elected are temporarily due no later than the end of the 45-day period after the end of the Outbreak Period. For all ongoing monthly premium payments, coming due during the Outbreak Period are temporarily due no later than 30 days after the end of the Outbreak Period because the premium payment is considered timely pursuant to the COBRA statute if paid within 30-day grace period of the due date. (A Participant is not permitted to pick and choose among the different months (such as May and August but not the other months) to pay a premium except that a Participant may choose to pay for only certain of the months in order of retroactivity (such a paying for April and May, but not choosing to pay for later months.

3. **COBRA Election Notice.** A Qualified Beneficiaries 60 day right to elect COBRA upon receipt of the Notice is temporarily tolled until after the end of the Outbreak Period, calculated from the later of the date of the Qualifying Event, if the Qualifying Event is a divorce or a child losing Dependent status, or the date the Qualified Beneficiary loses coverage. For Qualifying Events occurring on or after March 1, 2020, this period is extended until the end of the sixty (60) period after the end of the Outbreak Period.

4. **Special Enrollment Rights.** For Participants that experience a birth, marriage or adoption on or after March 31, 2020, the 30-day period to special enroll an eligible Dependent in the Plan upon birth, marriage, or adoption has been extended until 30 days from the end of the Outbreak Period. If you or your dependent lose coverage under Children's Health Insurance Program Reauthorization Act of 2009 (known as "CHIPRA") or Medicaid, you or your dependents 60-day period to special enroll in the Plan (subject to meeting the Plan's eligibility rules) upon a loss of CHIPRA or Medicaid coverage has been extended until 30 or 60 days from the end of the Outbreak Period.

5. **Plan's Claims Filing Procedure.** Any benefit claims filing requirements (including the one year period to file a lawsuit) mentioned throughout the Plan, for claims as of March I, 2020, have been temporarily tolled and counted from the end of the Outbreak Period (but any days that passed prior to the March I, 2020 start of the Outbreak Period will be accounted for and not disregarded in determination the claims filing deadline).

6. **Plan's Appeals Procedure.** For those claimants (or their authorized representatives) who received an appeal denial (also known as an adverse benefit determination) as of March 1, 2020, the claimant (or authorized representative) has 180 days counted from the end of the Outbreak Period to file an appeal (but any days that passed prior to the March I, 2020 start of the Outbreak Period will be accounted for and not disregarded in determining your claims filing deadline).

ARTICLE VI: MEDICAL AND PRESCRIPTION DRUG BENEFITS (COVERED EXPENSES)

If, as a result of non-occupational accidental injury or illness, a Covered Person incurs medical expenses described in this Article, the Plan shall reimburse the designated eligible charge for specified Outpatient and specified Inpatient expenses shown in the "SCHEDULE OF BENEFITS" actually incurred during a calendar year which exceed the amount of the deductible, but not to exceed the maximums specified in the "SCHEDULE OF BENEFITS," for:

SECTION 6.01 – HOSPITAL CHARGES

Charges made by the hospital while confined as an Inpatient or Outpatient.

SECTION 6.02 – X-RAY AND LABORATORY

Charges for x-ray and laboratory services performed which a physician has prescribed.

SECTION 6.03 – BLOOD

Charges for whole blood or blood plasma, and the cost of its administration.

SECTION 6.04 – ALLERGY SERUM

Charges for allergy serum preparation and its administration.

SECTION 6.05 – NURSING SERVICES

Charges made by a Registered Nurse or Licensed Vocational Nurse, for nursing services medically required and prescribed by a physician, while confined as an Inpatient.

SECTION 6.06 – PHYSIOTHERAPIST

Charges made by a Registered Physiotherapist not to exceed the amount as provided in the "SCHEDULE OF BENEFITS." Such therapy must be prescribed by a physician.

SECTION 6.07 – SPEECH THERAPY

Charges made by a qualified Speech Therapist for speech therapy provided that it is restorative or rehabilitative speech therapy for speech loss or impairment due to an injury or illness or due to surgery as a result of an illness other than a functional nervous disorder. Such therapy shall be prescribed by a physician.

SECTION 6.08 – MEDICALLY NECESSARY SUPPLIES

Charges for all medically necessary supplies such as casts, splints, trusses, braces, crutches, and surgical dressings and charges for artificial limbs and eyes replacing those initially lost due to illness or injury, and replacement if determined medically necessary.

SECTION 6.09 – SURGERY

Charges for necessary surgical expense incurred for:

1. the services of the principal surgeon, up to the charges of the contracted Network Allowance.

2. the services of one assistant surgeon, but not to exceed the charges of the contracted Network Allowance.

3. the services of an anesthetist or anesthesiologist, up to the charges of the contracted Network Allowance.

If, during a single surgical session, two or more procedures are performed either in the same operative field or through the same incision, only the largest Network Allowance amount for any one of such procedures will apply. If, during a single surgical session, two or more procedures are performed in different operative fields and through different incisions, the applicable Network Allowance amount will be the amount of the largest charge for any one of such procedures plus one-half of the sum of the Network Allowance amounts for the other procedures performed, not to exceed the actual amount charged.

SECTION 6.10 – PRESCRIPTION DRUGS

Charges for Outpatient prescription drugs are administered by **SavRx, Inc.** The Plan's group number with SavRx is Group IBEW234. You may contact Sav-Rx at (800) 228-3108.

No Annual Maximum for Prescription Drugs. There is no annual maximum for prescription drugs under the Plan.

A. MANDATORY USE OF GENERICS

The IBEW Local No. 234 Health and Welfare Plan has implemented a ***Mandatory Generic Program***. This program affects those members utilizing brand name medications which have a direct generic equivalent. ***This program is intended to provide additional savings to you*** and to the IBEW Local 234 Health and Welfare Plan without compromising your therapy.

You and your physician may determine which medication is best for you. Below are your options for coverage under the IBEW Local 234 Health and Welfare Plan prescription drug benefit:

1. If you are already taking the generic, there is no action required.

2. You may switch to the generic equivalent. Just ask your pharmacy to dispense the generic rather than the brand.

3. You may continue to purchase the brand name medication. ***However, because there is a federally rated generic equivalent available, you will be required to pay the brand name copay plus the difference in cost between the brand and generic medications***. Sav-Rx can accept a letter of Medical Necessity written by your physician to waive the difference in cost between the brand name and its equivalent generic – if there is a medical reason you are not able to take the generic. Your physician may fax a Letter of Medical Necessity to Sav-Rx at (888) 810-1394.

B. PRIOR AUTHORIZATION PROGRAM

In an effort to provide members with high quality, cost-effective services, your prescription plan sponsored by the IBEW Local No. 234 Health and Welfare Plan implemented the Sav-Rx Prior Authorization Program. This program manages the use of certain injectable and oral medication therapy which requires prior authorization before they can be processed through your prescription drug benefit. This requirement helps to ensure that members are receiving the appropriate drugs for the treatment of specific conditions and in quantities as approved by the U.S. Food and Drug Administration (FDA). In these cases, clinical criteria based on the most current medical information must be met.

If you have any questions about this program, please feel free to contact Sav-Rx toll free at (866) 233- IBEW (4239).

MORE INFORMATION ON GENERIC DRUGS
(Savings to you and the Plan in most situations)

Prescription drugs can be a costly medical expense for anyone; especially those with a chronic illness. Each state has a law that allows pharmacists to substitute less expensive generic drugs for many brand name products. Depending on your prescription needs, your savings could be significant. Here are some answers to common questions about generic drugs.

- ***What's the difference between a generic and brand name drug?***

  Not much, except for name and price. A generic drug is called by its chemical name; a manufacturer assigns a brand name. The products have the same ingredients. Standard practice and most state laws require that a generic drug be *generically equivalent* to its brand name counterpart. That is, it must have the same active ingredients, strength, and dosage form—pill, liquid or injection. The generic drug also must be *therapeutically equivalent*—it must be the same chemically and have the same medical effect.

- ***Do all drugs have generic equivalents?***

  No. Some drugs are protected by patents and are supplied by only one company. However, when the patent expires, other manufacturers can produce its generic version. Currently, about half the drugs on the market are available in generic form. However, your pharmacist can talk with your doctor about the prescription. Perhaps there's an acceptable generic drug that your doctor is not aware of. Your pharmacist can compare and evaluate generic and brand name drugs and may be able to consult with your doctor to provide the right medication at the best possible price.

- ***How can I get generic drugs?***

  Explain to your doctor and/or pharmacist that you want the most effective drug at the best price. Consider asking for generic drugs when they are available.

- ***Will my doctor automatically prescribe generic drugs?***

  It depends on the physician. You can ask your doctor to write a prescription permitting substitution of a generic drug product when appropriate.

Generic drugs can help save you money in many situations. For millions of Americans, the less expensive generic drugs mean the difference between getting necessary therapies and not being able to afford proper medical treatment. Another motivation in choosing generic medications is that, overall, the use of generic drugs helps to bring down the cost of medical insurance and benefits for everyone.

C. THERAPEUTIC QUANTITY LIMITS PROGRAM

The IBEW Local 234 Health and Welfare Plan has implemented the Sav-Rx Therapeutic Quantity Limits Program. This program is implemented to better adhere to FDA guidelines and industry standards for specific therapeutic classes of prescription drugs, as well as promote patient safety.

If your prescription is for a quantity above manufacturer and FDA guidelines, your prescription will reject at the pharmacy. In order for your medication to be covered under your prescription benefit, the pharmacy can adjust the quantity and fill the prescription for an amount that is written the guidelines. Sav-Rx understands that there are some circumstances where patients require doses outside of these parameters. If you require a quantity above the determined limit, the Sav-Rx Clinical Department can perform a Prior Authorization review for your prescription. To begin this process you, your pharmacist or the prescribing physician may contact Sav-Rx for Prior Authorization. Sav-Rx will consult with the prescribing physician to determine whether the additional quantity will be approved.

To initiate Prior Authorization or if you have any questions regarding this program, please call Sav-Rx toll free at (866) 233- IBEW (4239).

D. RETAIL PRESCRIPTION BENEFIT (Allows up to a 30-day supply)

Present your I.D. card and prescription(s) to the pharmacist who will collect a co-payment of 30% for brand name drugs that have a generic equivalent (non-preferred brand) and 20% for generic drugs and for brand name drugs without a generic equivalent (preferred brand), plus an additional $10 for each prescription or refill.

E. MAIL SERVICE PRESCRIPTION BENEFIT (Allows up to a 90-day supply)

If you or your eligible dependents take medication on an on-going basis (maintenance medication/90-day supply), you can receive prescription drugs via mail service for a co-payment, $20 for brand name drugs and $10 for generic drugs, and have them delivered to your home, postage paid. If you are currently taking medication, and you wish to use the mail service program, you must obtain a new prescription from your physician. A mail service brochure, a pre-addressed envelope and a Patient Profile Questionnaire are available from the Trust Fund Office.

F. COVERED DRUGS:

The following are covered benefits unless listed as an exclusion below.

1. Federal Legend Drugs
2. State Restricted Drugs
3. Compounded Medications
4. Insulin on Prescription Only
5. Needles and Syringes
6. OTC Diabetic Supplies
7. Clinically managed preventative statins

G. EXCLUSIONS:

The following are excluded from coverage unless listed as a benefit under “Covered Drugs”.

1. Anorexiants
2. Retin-A
3. Growth Hormones
4. Fertility Medications

5. Non-Federal Legend Drugs

6. Therapeutic devices or appliances

7. Drugs whose sole purpose is to promote or stimulate hair growth

8. Drugs labeled “Caution-limited by Federal Law to investigational use,” or experimental drugs, even though a charge is made to the individual.

9. Medication for which the cost if recoverable under any Workers’ Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.

10. Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.

11. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician’s original order.

12. Erectile dysfunction (such as Viagra) and female sex dysfunction (such as Addyi)

13. Abortifacients medications or supplies

14. Weight Loss medications or supplies

SECTION 6.11 – OXYGEN

Charges for oxygen and the rental of oxygen equipment, but not to exceed the purchase price of such equipment.

SECTION 6.12 – RENTAL OF CERTAIN ITEMS

Charges for the rental of a wheelchair, hospital bed and iron lung, but not to exceed the purchase price of such equipment.

SECTION 6.13 – CONVALESCENT CARE

Charges made by a Convalescent Care Facility for care and treatment except custodial care, resulting from injury or illness, not to exceed the allowable expense of the daily room and board maximum specified in the "SCHEDULE OF BENEFITS."

SECTION 6.14 – CHIROPRACTIC CARE

Charges for chiropractic care, within the scope of their license, not to exceed the amount provided in the "SCHEDULE OF BENEFITS." Preauthorization is not required for chiropractic care benefits.

SECTION 6.15 – AMBULANCE

Charges made for ambulance services rendered within twenty-four hours of the sudden and unexpected severe symptom of an illness or within 90 days of an accident for:

1. a licensed professional surface ambulance service to and from the nearest hospital; or

2. a licensed professional surface ambulance service from the hospital to the Covered Person's permanent place of residence; or

3. a licensed professional surface ambulance to the nearest hospital with the necessary equipment and facilities if treatment cannot be performed at the initial hospital; or

4. a licensed professional air ambulance, subject to medical review and a determination that it is medically necessary.

SECTION 6.16 – PHYSICIAN VISITS

Charges for physician's home, office and hospital visits.

SECTION 6.17 – RADIOTHERAPIST

Charges made by a physician, as defined in the Plan who is a professional radiotherapist.

SECTION 6.18 – MENTAL HEALTH CARE

Charges made for Inpatient or Outpatient Mental Health Care received in a hospital or in a physician's office

SECTION 6.19 – STERILIZATION

Charges for elective or medically required reproductive system sterilization performed by a physician.

SECTION 6.20 – MEDICALLY NECESSARY OR CRIME RELATED ABORTIONS

Charges for medically required or a crime related abortion performed by a physician.

SECTION 6.21 – CIRCUMCISION CHANGES

Charges made by a physician for circumcision surgery.

SECTION 6.22 – ORGAN OR TISSUE TRANSPLANTS

Charges for organ and tissue transplants which are non-investigative and non-experimental. This includes without limitation a bone marrow stem cell transplant. This would include charges incurred by (a) a Covered Person who receives the organ or tissue; (b) the Covered Person who donates the organ or tissue; (c) a tissue donor who is not a Covered Person if the organ or tissue recipient is a Covered Person.

Transplants, such as liver transplants, which have to meet certain criteria to be covered by Medicare, shall meet the same criteria to be covered by this Plan.

SECTION 6.23 – CHEMOTHERAPY

Charges for chemotherapy as medically necessary, excluding experimental or research drugs.

SECTION 6.24 – RENAL DIALYSIS

Charges for services and supplies for renal dialysis.

SECTION 6.25 – ACUPUNCTURE

Charges for treatment by acupuncture when treatment is performed by a physician or an acupuncturist licensed by the State.

SECTION 6.26 – HOME HEALTH CARE

Charges for home health care services, except that the Trust shall not pay for home health care unless: (1) the Plan of home health care is prepared, or approved, by the Covered Person's physician; and (2) the Trust validates the physician's certification that: (a) the home health care is medically necessary; and (b) in the absence of the home health care, the Covered Person would be an Inpatient at a hospital or convalescent hospital.

Home health care covered charges shall include only the following charges for medical services and supplies furnished on a visiting basis in the Covered Person's home for treatment of the Covered Person's bodily injury or disease:

1. The charge for the services of a home health aide, LVN or RN on a part-time or intermittent basis. The Trust shall not pay more than the maximum visit benefit for each visit by a home health aide or for more than 100 such visits during one calendar year. One home health aide visit shall be a visit of four hours or less.

2. The charge for nutrition counseling. The Trust shall not pay more than the nutritional counseling maximum for all such charges during one calendar year.

3. The charge for Mental Health Care by a licensed social worker who is practicing within the scope of the license.

Home Health Care - shall mean medical care that is furnished by or through a home health agency to a Covered Person in the Covered Person's home.

Home Health Agency - shall mean an agency that: (1) meets all legal licensing required by the state or other locality in which it is situated, or (2) qualifies as a participating home health agency under Medicare.

SECTION 6.27 – HOSPICE CARE - Hospice care covered charges shall be limited to:

1. the charge for the confinement of a terminally ill Covered Person as an Inpatient in a hospice;

2. the charge for home health care furnished to the terminally ill Covered Person in the Covered Person's home;

3. the charge for medical social services furnished to the terminally ill Covered Person or to members of the Covered Person's family;

4. the charge for bereavement counseling furnished to members of the Covered Person's family during the 12-month period beginning on the Covered Person's date of death.

Hospice Care Limitations - Hospice care benefits are payable only for covered charges incurred by a Covered Person who is a terminally ill patient or by members of the Covered Person's family. The Trust shall not pay: (1) more than the hospice maximum for all hospice care charges incurred either by the terminally ill Covered Person or the members of the Covered Person's family before the death of the terminally ill Covered Person; or (2) more than $200 for bereavement counseling.

Hospice Care - shall mean care that: (1) is furnished or arranged by a hospice that is approved by the Trust, (2) is provided as part of a coordinated plan of home and Inpatient care designed to meet the special needs of the terminally ill Covered Person and the members of the Covered Person's family due to the terminal illness, (3) is for the terminally ill Covered Person, may include medical care, palliative care, respite care and medical social services, and (4) is for medical social services and bereavement counseling for the Covered Person's family.

Hospice - shall mean an agency or facility that is approved by the Trust as meeting established standards, including any legal licensing required by the state or other locality in which it is situated.

Medical Social Services - shall mean counseling furnished to the terminally ill Covered Person or to the members of the Covered Person's family to assist each in coping with the dying process of a terminally ill Covered Person. The counseling may be furnished by a social worker or a pastoral counselor, but only if such person is licensed and practicing within the scope of the license.

Palliative Care - shall mean care that is rendered to relieve the symptoms or effects of a disease without curing the disease.

Respite Care - shall mean care that is furnished a terminally ill Covered Person so that the members of the Covered Person's family may have relief from the stress of caring for the terminally ill Covered Person.

Terminally Ill Covered Person - A Covered Person whose physician has certified is (1) terminally ill, and (2) expected to live 6 months or less.

SECTION 6.28 – WELL CHILD CARE

Well child care includes:

1. the charge of an acute care hospital for routine nursery care furnished to a newborn well baby while the mother is an Inpatient;

2. the charge of a physician for the initial pediatric examination of a newborn performed before the child is released from nursery care;

3. the charges of a physician for no more than 15 Outpatient visits through the age of 5 years;

4. the covered services at each Outpatient visit may include a history, physical examination, developmental assessment, anticipatory guidance, appropriate immunizations and laboratory tests, in keeping with prevailing medical standards.

SECTION 6.29 – WELL ADULT CARE

Well Adult Care covers:

1. Females - Age 18 and older, one annual cervical cancer screening examination, including PAP smear, a breast examination and for age 40 and older a mammogram as recommended by the American Cancer Society.

2. Males - Prostate cancer screening, PSA blood test and digital rectal examination, as recommended by a physician.

SECTION 6.30 – VISION CARE

Vision care benefits are provided through VSP. VSP covers each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction. The summary of benefits is on page 7.

SECTION 6.31 – MASTECTOMIES

Charges for:

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

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; or

3. Prosthesis and physical complications of all stages of mastectomy, including lymphedemas.

SECTION 6.32 – PHYSICAL EXAMINATIONS

Charges incurred by a covered person for a physical examination are payable at the rate applicable to the provider performing the physical examination subject to usual, customary and reasonable limitations, except that there is no coverage if the physical examination is required as a condition of employment or that is necessary for a license.

SECTION 6.33 – IMMUNIZATIONS

Immunizations consistent with generally accepted medical standards are covered.

SECTION 6.34 – PHYSICAL THERAPY

The Plan will pay for physical therapy visits up to **twenty** per calendar year. Preauthorization is not required for physical therapy visits.

SECTION 6.35 – MIDWIFE SERVICES

Charges incurred by a covered person for a Midwife services subject to usual, customary and reasonable limitations. Midwife services include but are not limited to obstetrical (medical care involving a woman and her baby during pregnancy, childbirth and the period shortly after birth), supervision, care and advice to women during pregnancy, labor, birth and the postnatal period, care for the unborn infant, and gynecological services (medical care involving the female reproductive organs). Such services include commencing emergency procedures in the absence of medical help. A Midwife must have acquired the appropriate qualifications to be licensed to practice Midwifery as well as having obtained professional liability insurance.

SECTION 6.36 – PREVENTIVE CARE BENEFITS

The Plan provides in-network preventive care benefits consistent with the Affordable Health Care Act. Such preventive care benefits are not covered in out-of-network facilities except as is otherwise provided in this Plan. Preventive care benefits are paid at 100% if provided in a network facility.

Pursuant to the Interim Final Regulations Relating to Coverage of Preventive Services under the Patient Protection and Affordable Care Act issued by the Department of Health and Human Services on July 19, 2010, the preventive care services listed below are provided without additional cost, subject to the following rules: If a recommended preventive service is billed separately (or is tracked as individual encounter data separately) from an office visit, then the Plan's cost-sharing requirements apply with respect to the office visit. If a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is the delivery of such an item or service, then there shall be no cost-sharing with respect to the office visit. If a recommended preventive service is not billed separately (or is not tracked as individual encounter data separately) from an office visit and the primary purpose of the office visit is not the delivery of such an item or service, then the Plan's regular cost-sharing requirements apply.

Subject to the above, in-network preventative care benefits include the following:

A. **<u>Covered Preventive Services for Adults</u>:** The Plan shall provide the following covered preventive services for adults (age 18 or above):

1. Abdominal Aortic Aneurysm one-time screening for men aged 65 to 75 who have ever smoked

2. Alcohol Misuse screening and counseling

3. Aspirin therapy regimen for men ages 45 to 79 years and women ages 55 to 79 years for the prevention of cardiovascular disease

4. Blood Pressure screening

5. Cholesterol screening every 5 years for adults of certain ages or at higher risk of cardiovascular disease:

    a. Men age 35 and older
    b. Men ages 20 to 35 if they are at increased risk for coronary heart disease
    c. Women age 45 and older
    d. Women ages 20 to 45 if they are at increased risk for coronary heart disease

6. Colorectal Cancer screening every 5 years for adults between the ages of 50 and 75 years

7. Depression screening in patients with a history of depression, unexplained somatic symptoms, psychological conditions, substance abuse, or chronic pain, as approved by the plan

8. Type 2 Diabetes screening every 3 years for adults with high blood pressure

9. Dietary counseling for adults at higher risk for diet-related chronic diseases, particularly heart disease and diabetes, or as recommended by a physician

10. HIV screening every year for adults at higher risk of exposure to HIV

11. Immunization vaccines for adults (recommended ages, populations and doses vary), including without limitation, for Meningococcal vaccine (meningitis), Tetanus, HPV (human papillomavirus), Influenza, Pneumococcal vaccine, Shingles (Herpes zoster), Polio, and combination Measles, Mumps, Rubella and Varicella (smallpox) Vaccine)

12. Shots for influenza and pneumonia prevention

13. Obesity screening and weight loss counseling for obese adults

14. Sexually Transmitted Infection (STI) prevention counseling and screening every year for adults at higher risk of exposure to STI (such as Gonorrhea, Syphilis, Chlamydia)

15. Tobacco Use screening and cessation measures such as counseling and pharmacotherapy for tobacco users

16. Age-appropriate preventative medical examinations (not to exceed 2 visits per year)

17. Bone density testing screening for osteoporosis every two years

B. **<u>Covered Preventive Services for Women, Including Pregnant Women</u>:** The Plan shall provide the following preventive service for women, including pregnant women:

1. Age-appropriate preventative medical examinations (not to exceed two visits per year)

2. Scheduled prenatal office visits and first postpartum visit

3. Iron deficiency anemia screening on a routine basis for pregnant women

4. Bacteriuria urinary tract or other infection screening for pregnant women

5. Genetic counseling and evaluation for genetic testing (one-time) for women at higher risk because of the hereditary presence of breast cancer genes BRCA1 and BRCA2.

6. Breast Cancer Mammography screenings every 1 to 2 years for women over 40

7. Breast Cancer Chemoprevention counseling for women at higher risk for breast cancer

8. Breast Feeding counseling and consultations with a trained provider and costs for renting breastfeeding equipment, in conjunction with each birth

9. Gestational diabetes screening for pregnant women between 24 and 28 weeks of gestation and at the first prenatal visit for pregnant women identified to be at high risk for diabetes

10. Cervical Cancer screening every 3 years for sexually active women with a cervix

11. Chlamydia Infection screening every year for women aged 24 and younger and for older women who are at increased risk

12. Contraceptive methods and counseling for all women with reproductive capacity, as prescribed.

13. Domestic and interpersonal violence counseling and screening every year.

14. Folic Acid supplements for women who may become pregnant

15. Gonorrhea screening every year for women at increased risk

16. Hepatitis A and B screening every year for pregnant women at their first prenatal visit

17. Human papillomavirus DNA testing every 3 years in women with normal cytology results, beginning at 30 years of age.

18. Osteoporosis screening for women over age 60 every two years at risk of osteoporosis-related fractures and routine screening for women over age 65

19. Rh incompatibility screening for pregnant women at their first prenatal visit and follow-up testing for women at higher risk as determined by the treating physician

20. Tobacco Use screening and counseling for all women, and expanded counseling for pregnant tobacco users

21. Syphilis screening for pregnant women or other women at increased risk

C. **Covered Preventive Services for Children.** The Plan shall provide the following Covered Preventive Services for children (age 17 or below unless otherwise noted):

1. Age-appropriate preventative medical examinations (not to exceed two visits per year)
2. Alcohol and Drug Use assessments for adolescents
3. Autism screening for children at 18 and 24 months
4. Behavioral assessments
5. Blood Pressure screening annually
6. Cervical Dysplasia screening every three years for sexually active females
7. Congenital Hypothyroidism screening for newborns
8. Depression screening for adolescents at higher risk
9. Developmental screening for children under age 3, and surveillance throughout childhood
10. Dyslipidemia screening for children at higher risk of lipid disorders
11. Fluoride supplements for children without fluoride in their water source
12. Gonorrhea preventive medication for the eyes of all newborns
13. Hearing screening for newborns
14. Height, Weight and Body Mass Index measurements at regular intervals
15. Hematocrit or Hemoglobin screening between the ages of 9-12 months and then 6 months later; for children at high risk, screen once a year from ages 2 to 5 years.
16. Hemoglobinopathies or sickle cell screening for newborns
17. HIV screening for adolescents at higher risk of exposure to HIV
18. Immunization vaccines for children from birth to age 18 (as recommended by the physician)
19. Iron supplements for children ages 6 to 12 months at risk for anemia
20. Lead screening for children at risk of exposure
21. Medical History for all children throughout development
22. Obesity screening and counseling for children ages 6 years and older with Body Mass Index at or above the 95th percentile
23. Oral Health risk assessment for young children
24. Phenylketonuria (PKU) screening in newborns
25. Sexually Transmitted Infection (STI) screening, prevention, and counseling for adolescents at higher risk of exposure to STIs
26. Tuberculin testing for children at higher risk of tuberculosis

27. Vision screening (annual)

28. The Board of Trustees interprets this provision consistent with guidance issued by the Department of Health and Human Services and/or the EBSA.

WHEN A PREVENTIVE VISIT LEADS TO NON-PREVENTIVE SERVICES

Preventive care is an important part of catching health problems early - that is why most preventive care services are covered at little or no cost. But sometimes when you come in for a preventive care visit, you end up getting other, non-preventive services, for which you may have to pay for the services. For example, you come in for a routine physical exam. During your visit, your doctor finds a mole that needs to be moved for testing. Removing the mole and testing it are non-preventive care services. Later you may a receive a bill for a copay or coinsurance for those services.

SECTION 6.37 – NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

Pursuant to the Newborns' and Mothers' Health Protection Act of 1996, the Medical Plan does not restrict benefits for any hospital length of stay for the mother or newborn child to less than 48 hours following a normal vaginal delivery or less than 96 hours following a cesarean section delivery.

In accordance with Federal Law, those Plans do not require that a provider obtain preauthorization under those Plans for either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than the applicable time period.

SECTION 6.38 – WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

Your Plan covers medical and surgical benefits for mastectomies. Under a federal law known as the Women's Health and Cancer Rights Act of 1998, group health plans that provide medical and surgical benefits in connection with a mastectomy must provide benefits for certain reconstructive breast surgery. For a Participant or dependent who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending physician and the patient for:

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

2. Surgery and reconstruction of the other breast to produce a symmetrical appearance; or

3. Prosthesis (artificial replacement) and service for physical complications of all stages of mastectomy, including lymphedemas.

This coverage is subject to the Plan's annual deductibles and co-payment provisions.

SECTION 6.39 – MATERNITY CHARGES

Maternity-related services have been extended to eligible dependent children up to age 26.

Maternity-related services for a Participant or Spouse are Covered Charges. Charges due to elective abortion are not Covered Charges except where the life or health of the mother would be endangered if the fetus were carried to term, or those charges that directly result from complications of an abortion. Expenses for "well-baby" care are not covered, with the exception of a "well baby Physician's Hospital visits." For this purpose, "complications of pregnancy" means (i) conditions that require Hospital confinements (when the pregnancy is not terminated), whose diagnoses are distinct from pregnancy, and (ii) non-elective Cesarean section, ectopic pregnancy that is terminated, and spontaneous termination of pregnancy that occurs during a period of gestation in which a viable birth is not possible.

A. **Extended Maternity Coverage.** A Participant or Spouse who is pregnant on the date of termination of her coverage will be entitled to the applicable benefits for covered expenses due to her pregnancy even though she may not be totally disabled on the date of termination provided (i) the pregnancy commenced while such individual was eligible for coverage under the Plan and (ii) such individual is not eligible for coverage under any other group plan providing similar benefits for the pregnancy.

B. **Coverage of Post-Delivery Hospital Stay.** Charges for maternity-related care will be provided on the same basis as any other illness, except that charges for in-patient Hospital treatment for childbirth delivery will be provided for the mother's newborn child for 48 hours following normal vaginal delivery and 96 hours following delivery by Caesarean section. The mother and newborn child may be discharged earlier than the above indicated time periods if (i) the treating Physician or Other Accredited Provider, in consultation with the mother, makes the decision to discharge the mother and child for an earlier time period, and (ii) a post discharge follow-up visit for the mother and newborn child if provided within 48-hours of discharge if prescribed by the treating Physician and the visit is provided by an Other Accredited Provider whose scope of practice includes postpartum care and newborn care.

SECTION 6.40 – ANESTHESIA

For anesthesia and its administration.

SECTION 6.41 – SLEEP APNEA

The Plan covers sleep apnea mouth guards at a maximum of $2,000 for both in and out-of-network facilities, with a three-year waiting period (which applies to each type of sleep apnea machine or device (such as C-pap, bi-ap and APAP)).

SECTION 6.42 – HEARING AIDS

All eligible active Participants, non-Medicare retirees and their dependents have access to a $1,500 per ear allowance for medically necessary hearing aid devices with a 36-month frequency limitation period per device beginning on the date of purchase. A Participant pays the amount in excess of $1,500. After the 36-month period, the $1,500 per ear allowance renews. To receive reimbursement for hearing aid device purchases up to the $1,500 per ear allowance, the Participant or dependent is required to submit a copy of the itemized invoice and receipt as well as a prescription for the device to the Fund Office. The invoice must include the name of the patient, date of service, description of each service and the amount charged for each service. The $1,500 allowance can be applied to any medically necessary hearing aid device and provider of choice.

SECTION 6.43 – AUTISM SPECTRUM DISORDER

Charges for the diagnosis and treatment of medically necessary Autism Spectrum Disorder including the evaluation or treatment of learning disabilities and minimal brain dysfunction, developmental, learning and communication disorder, will be covered when prescribed, provided or ordered by a certified or licensed health care professional. Benefits may include but are not limited to outpatient services such as psychotherapy, physical therapy, Applied Behavior Analysis (ABA Therapy) as well as inpatient treatment if medically necessary. Autism Spectrum Disorder includes any of the pervasive development disorders as defined in the most recent edition of the Diagnostic and Statis manual of mental disorders published by the American Psychiatric Association (such as autism, autistic disorder, Asperger syndrome and pervasive development disorder not otherwise specified (PDD-NOS)). Benefits for autism are payable the same as any other covered illness under the Plan rules. No annual or lifetime dollar visit limits apply to the diagnosis and treatment of Autism Spectrum Disorder.

SECTION 6.44 – TELEHEALTH VISITS COVERED (also known as Virtual Office Visits)

The Plan provides coverage for Telehealth visits (such as video or telephone calls with physicians and other medical personnel). These are also known as "virtual visits".

These visits will be covered by the Plan in the same manner as an in-person visit to your physician or other medical provider would cost. Please note that telehealth visits specifically related to COVID-19 testing are covered without cost-sharing. This change is effective as early as March 1, 2020.

SECTION 6.45 – TEMPORARY EMERGENCY EXTENSION RULES DURING PUBLIC HEALTH EMERGENCY

Effective immediately, joint IRS and DOL emergency regulation requires that the Plan (and insurance carriers and health maintenance organizations) must disregard the period from **March 1, 2020 until sixty (60) days after the announced end of the National Emergency or another date determined by the agencies in a future notice** (referred to as the "**Outbreak Period**") for all Plan Participants, beneficiaries, qualified beneficiaries, or claimants wherever located in determining the following periods and dates:

1. **COBRA Qualifying Event Notice.** For Qualifying Events or receipts of the notice of COBRA continuation coverage occurring on or after March 1, 2020, the 60-day period to give a Qualifying Event Notice will be temporarily tolled until 60 days after the end of the Outbreak Period (which is an unknown date at this stage);

2. **COBRA Premium Payments (For Initial Payment and Ongoing Monthly Payments).** If COBRA coverage is first elected during the Outbreak Period, all monthly premium payments for all months for which coverage is elected are temporarily due no later than the end of the 45-day period after the end of the Outbreak Period. For all ongoing monthly premium payments, coming due during the Outbreak Period are temporarily due no later than 30 days after the end of the Outbreak Period because the premium payment is considered timely pursuant to the COBRA statute if paid within 30 day grace period of the due date. (A Participant is not permitted to pick and choose among the different months (such as May and August but not the other months) to pay a premium except that a Participant may choose to pay for only certain of the months in order of retroactivity (such a paying for April and May, but not choosing to pay for later months.

3. **COBRA Election Notice.** A Qualified Beneficiaries 60 day right to elect COBRA upon receipt of the Notice is temporarily tolled until after the end of the Outbreak Period, calculated from the later of the date of the Qualifying Event, if the Qualifying Event is a divorce or a child losing Dependent status, or the date the Qualified Beneficiary loses coverage. For Qualifying Events occurring on or after March 1, 2020, this period is extended until the end of the sixty (60) period after the end of the Outbreak Period.

4. **Special Enrollment Rights.** For Participants that experience a birth, marriage or adoption on or after March 31, 2020, the 30-day period to special enroll an eligible Dependent in the Plan upon birth, marriage, or adoption has been extended until 30 days from the end of the Outbreak Period. If you or your dependent lose coverage under Children's Health Insurance Program Reauthorization Act of 2009 (known as "CHIPRA") or Medicaid, you or your dependents 60-day period to special enroll in the Plan (subject to meeting the Plan's eligibility rules) upon a loss of CHIPRA or Medicaid coverage has been extended until 30 or 60 days from the end of the Outbreak Period.

5. **Plan's Claims Filing Procedure.** Any benefit claims filing requirements (including the one year period to file a lawsuit) mentioned throughout the Plan, for claims as of March 1, 2020, have been temporarily tolled and counted from the end of the Outbreak Period (but any days that passed prior to the March 1, 2020 start of the Outbreak Period will be accounted for and not disregarded in determining the claims filing deadline).

6. **Plan's Appeals Procedure.** For those claimants (or their authorized representatives) who received an appeal denial (also known as an adverse benefit determination) as of March 1, 2020, the claimant (or authorized representative) has 180 days counted from the end of the Outbreak Period to file an appeal (but any days that passed prior to the March 1, 2020 start of the Outbreak Period will be accounted for and not disregarded in determining your claims filing deadline).

SECTION 6.46 – INTERNATIONAL TRAVEL

Healthcare Coverage When You Are Traveling Or Living Abroad
As a Blue Cross and Blue Shield member, you take your healthcare benefits with you when you are abroad. Through the Blue Cross Blue Shield Global® Core program, you have access to doctors and hospitals around the world.

To take advantage of the program:

- Always carry your current member ID card.
- Before you travel, contact your Blue Cross and Blue Shield (BCBS) company for coverage details.
- Coverage outside the United States may be different.
- If you need to locate a doctor or hospital, call the Service Center for Blue Cross Blue Shield Global Core (see number below). An assistance coordinator, in conjunction with a medical professional, will arrange a physician appointment or hospitalization if necessary.
- If you need inpatient care, call the Service Center (see number below) to arrange direct billing. In most cases, you should not need to pay upfront for inpatient care except for the out-of-pocket expenses (noncovered services, deductible, copayment and coinsurance) you normally pay. The hospital should submit the claim on your behalf.
- In addition to contacting the Service Center, call your BCBS company for precertification or preauthorization. Refer to the phone number on the back of your member ID card. Note: *This number is different from the phone number listed below*.
- For outpatient and doctor care or inpatient care not arranged through the Service Center, you may need to pay upfront. Complete a Blue Cross Blue Shield Global Core International claim form and send it with the bill(s) to the Service Center (the address is on the form). You can also submit your claim online or through the Blue Cross Blue Shield Global Core mobile app. The claim form is available from your BCBS company or online at www.bcbsglobalcore.com.
- In an emergency, go directly to the nearest hospital.

To learn more about Blue Cross Blue Shield Global Core:

- Visit www.bcbsglobalcore.com.
- Use the Blue Cross Blue Shield Global Core app for Android*, iPhone, and iPod touch.** (Rates from your wireless provider may apply).
- Call your BCBS company.
- Call the Service Center at 1 (800) 810-2583 or collect at 1 (804) 673-1177, 24 hours a day, seven days a week.

ARTICLE VII: MEDICAL DEDUCTIBLE AMOUNT

SECTION 7.01 – CALENDAR YEAR DEDUCTIBLE

The Deductible Amount applies during each calendar year and is satisfied when Covered Expenses incurred by a Covered Person exceeds the Deductible Amount specified in the "SCHEDULE OF BENEFITS." The calendar year deductible is waived when there is dual coverage and the Trust is the secondary plan. The Board of Trustees may amend or otherwise change the schedule of benefits at any time.

SECTION 7.02 – EMPLOYEE AND DEPENDENT

The Deductible Amount shall apply separately to the Employee and to each Dependent. With respect to any Covered Person covered under this Plan, both as an Employee and as a Dependent during the same calendar year, only one Deductible Amount shall apply to all Covered Expenses incurred by or on behalf of such person during the calendar year, provided that the coverage on such person was in effect continuously from the date on which the Deductible Amount was satisfied.

SECTION 7.03 – NO ANNUAL OR LIFETIME MAXIMUMS

The Medical Plan no longer contains lifetime or annual maximums.

SECTION 7.04 – TEMPOROMANDIBULAR JOINT (TMJ)

The Maximum Benefit that shall be paid for Covered Charges incurred by a Covered Person during his lifetime for treatment of a TMJ disorder is $1,000.00. TMJ Disorder means a disorder, disease, or dysfunction of the TMJ, regardless of the diagnosis. Reinstatement provisions as described in 7.03 are not applicable to TMJ disorders.

ARTICLE VIII: MEDICAL PLAN EXCLUSIONS

The benefits described herein do not cover:

SECTION 8.01 – EXCESS OF REASONABLE AND CUSTOMARY

Any portion of a charge that is in excess of the Reasonable and Customary charge for the treatment.

SECTION 8.02 – EMPLOYMENT RELATED INJURIES/CONDITIONS

This includes without limitation charges for any condition or disability which would entitle the Covered Person to any benefit under a Workers' Compensation Act or similar legislation or which is due to injury or illness arising out of or in the course of any occupation or employment for wage or profit.

SECTION 8.03 – GOVERNMENT PROVIDED SERVICES

Services provided to the eligible patient by any Federal or State Government Agency or are provided without cost to the eligible patient by any municipality, county or other political subdivision, except as provided in Section 12432.5 of the California Government Code. This includes without limitation, medical care for treatment services or supplies in a hospital owned or operated by the United States Government, any agency thereof, or a State or political subdivision, or paid for by the United States Government, or any agency thereof, or by any State, or any medical care or treatment, services or supplies for which the Covered Person is not required to pay and/or has no legal obligation to pay. This also includes charges for benefits which are payable under Parts A and B of the Federal Medicare Act.

SECTION 8.04 – THIRD PARTY LIABILITY

Services for which a third party may be liable or legally responsible.

SECTION 8.05 – SERVICES PERFORMED BY A RELATIVE AND/OR PERSON LIVING IN THE HOUSEHOLD

Services performed by a person who lives in your home or is related to you by blood or marriage. This would also include services performed by a person who ordinarily resides in the Covered Person's household or who is related to the Covered Person or the Covered Person's spouse as a spouse, parent, child, brother, or sister, whether such relationship is by blood or exists in law.

SECTION 8.06 – CHARGES PATIENT WOULD NOT BE LIABLE FOR IN THE ABSENCE OF INSURANCE/PLAN BENEFITS

Charges for which the patient would not otherwise be liable for in the absence of insurance.

SECTION 8.07 – SERVICES FOR WHICH THE PATIENT HAS NO LEGAL OBLIGATION OR REQUIRED TO PAY

Charges for services for which the Participant/patient is not legally required to pay and charges for which the Plan would not be legally obligated to pay in the absence of this Plan.

SECTION 8.08 – EXPERIMENTAL OR INVESTIGATIONAL PROCEDURES/TREATMENT

Any experimental or investigational procedures or treatment; or any course of treatment whether or not prescribed by a physician, for which charges incurred are not the direct result of injury or illness, and any other procedure not recognized to have medical significance or therapeutic value; or any course of treatment making use of drugs or devices not yet approved by the Federal Drug Administration.

SECTION 8.09 – CHARGES RESULTING FROM WAR, CRIME, PARTICIPATION IN RIOT OR INSURRECTION

Any charges resulting from war, declared or not, armed aggression, in the commission of a crime, or participation in a riot or insurrection.

SECTION 8.10 – SURROGATE PREGNANCY

Treatment related to a Surrogate Pregnancy in which the Participant and/or Dependent acts as the Surrogate in a surrogate pregnancy. This exclusion applies to any and all costs related in any way to the surrogate pregnancy, including delivery costs. This Exclusion also applies if there is a miscarriage or other complications related to the surrogate pregnancy.

SECTION 8.11 – COSMETIC OR PLASTIC SURGERY

Cosmetic or plastic surgery and/or treatment, including sex transformation surgery, except that expenses incurred for:

1. Treatment of congenital abnormality in a New born child who is covered as indicated under "eligibility" shall be covered;

2. Procedures that are necessary for post-traumatic or post-oncology treatment shall be covered if the original condition necessitating said surgery occurred while this coverage is in force with respect to the Covered Persons;

3. Medical and surgical benefits for mastectomies pursuant to Plan Section 6.31; and

4. Medically necessary sex transformation surgery (effective June 1, 2017).

SECTION 8.12 – UNNECESSARY VISITS

Examination or visits not incidental to or necessary to diagnose or treat an injury or illness.

SECTION 8.13 – NOT UNDER CARE OF PHYSICIAN

Injury or illness for which the Covered Person on whose behalf claim is presented is not under the regular care of a physician.

SECTION 8.14 – WELL CHILD CARE

Well Child Care, except as provided in the "SCHEDULE OF BENEFITS."

SECTION 8.15 – ILLEGAL ACT

Injury or illness resulting from or sustained as a result of being engaged in an illegal act (such as evidence of a DUI) and/or commission of or attempted commission of an assault or felonious act. No criminal conviction is required for this exclusion.

SECTION 8.16 – HEARING EXAMINATIONS

Charges for hearing examinations.

SECTION 8.17 – SERVICES OUTSIDE THE UNITED STATES

Charges for services received or supplies purchased outside the United States, Canada or Mexico, unless the charges are incurred while traveling on business or for pleasure outside the United States, Canada or Mexico.

SECTION 8.18 – CERTAIN OBESITIES

Exogenous obesity is not a covered disability under the Plan and the Plan shall not pay for any expenses incurred involving treatment for same, except as specifically set forth herein and confirmed by a minimum of two legally qualified physicians.

All ileojejunostomy (intestinal bypass) shall be considered a Covered Expense under the Plan only if the following criteria are met:

1. the claimant is 100% over his medically desirable weight;

2. the obesity is a threat to life due to other complicating health factors, such as diabetes, heart trouble or hypertension;

3. the Covered Person has a history of unsuccessful attempts to reduce weight by more conservative measures.

In order to determine that the Covered Person qualifies for coverage, the following information shall be obtained from the attending physician:

1. the pathological source of the obesity and the tests that have been performed to support the diagnosis;

2. other serious disabilities of the Covered Person which are complicated by the obesity;

3. the Covered Person's presurgical weight and height;

4. detail of the conservative treatment which was attempted prior to the decision to perform the surgery.

If the Covered Person qualifies for coverage of the surgical benefit, then any other applicable benefits of the Plan shall also be payable.

SECTION 8.19 – GASTRIC BYPASS

Charges as a result of gastric by-pass or stapling surgery reversal.

SECTION 8.20 – STERILIZATION REVERSAL

Charges as a result of reproductive system sterilization reversal.

SECTION 8.21 – ELECTIVE ABORTION

Charges as a result of elective abortion.

SECTION 8.22 – EXPERIMENTAL NEW PROCEDURES

Charges as the result of new or experimental procedures.

SECTION 8.23 – TEETH SERVICES

Charges for services performed on or to the teeth, nerves of the teeth, gingivae or alveolar processes, except to tumors or cysts or as otherwise specifically included herein.

SECTION 8.24 – FERTILITY-RELATED SERVICES

Charges for infertility testing and/or charges for services for treatment to promote fertility, including any impregnation technique such as artificial insemination, in vitro fertilization and development of an embryo, or implantation of an embryo developed in vitro.

SECTION 8.25 – CERTAIN EQUIPMENT

Charges for air purifiers, air conditioners, humidifiers, exercise equipment and supplies for comfort, hygiene, or beautification; educational services, telephone consultations, nutritional counseling or food supplements.

SECTION 8.26 – ELEVATORS, RAMPS AND SIMILAR ITEMS

Charges for rental or purchase of ramps, elevators, stair-lifts, swimming pools, hot tubs, or filtering systems, or car hand controls, whether or not their use or installation is for purposes of providing therapy or easy access.

SECTION 8.27 – FACILITY OR LAND MODIFICATIONS

Charges for any modification made to dwellings, property, or motor vehicles, whether or not their use or installation is for purposes of providing therapy or easy access.

SECTION 8.28 – NON-MEDICAL ITEMS

Any services, supplies, charges or expenses which are not included as medical benefits.

SECTION 8.29 – NO PAYMENTS REQUIRED

Charges that would not have been made if no coverage existed, or charges that neither this Plan nor the Covered Person is required to pay.

SECTION 8.30 – PHONE CONSULTATIONS, FORM COMPLETIONS, MISSED APPOINTMENTS

Telephone consultations missed appointments or fees for filling out a claim form.

SECTION 8.31 – NON-PHYSICIAN RECOMMENDED ITEMS

Charges for services and supplies not recommended and approved by the attending physician.

SECTION 8.32 – DEPENDENT CHILDREN MATERNITY BENEFITS

Maternity benefits are provided to eligible Dependent children up to age 26. Expenses incurred by a newborn of a Dependent child are not covered under the Plan unless the newborn of the Dependent child is also considered an Eligible Dependent under the Plan rules.

SECTION 8.33 – EXCESS CHANGES

Charges in excess of the allowable fee.

SECTION 8.34 – NON-FDA APPROVED ITEMS

Medications or medical appliances which have been prescribed for illness, injury, or condition not approved by the U.S. Food and Drug Administration.

SECTION 8.35 – SEXUAL DYSFUNCTION ISSUES

Therapy or surgery for sexual dysfunction including impotency due to a medical or mental disease. Included in this exclusion are penile implants and/or repairs thereto.

SECTION 8.36 – NON-VALUABLE SERVICES

Services or expenses that cannot reasonably be expected to lessen the Covered Person's illness, injury or condition and to enable him to live outside of an institution.

SECTION 8.37 – EYE-RATED ITEMS

Eyeglasses, frames, contact lenses, eye refractions or eye examinations for the correction of vision or fitting of glasses, optometric services, optician services, orthoptics, and other vision training except as provided for under the Vision Care benefit provided in the "SCHEDULE OF BENEFITS."

SECTION 8.38 – VITAMINS AND MINERALS

EXCEPT for Vitamin B-12 injections for the treatment of Vitamin B-12 deficiency.

SECTION 8.39 – VITAMIN C OR ASCORBIC ACID THERAPY IV.

SECTION 8.40 – CERTAIN DIAGNOSTIC, PHYSICAL THERAPY, REHAB

Admissions for diagnostic study, physical therapy, rehabilitative care, or environmental control, when Inpatient bed care is not medically necessary.

SECTION 8.41 -- SERVICES OF RESIDENTS OR INTERNS

SECTION 842 – PAIN MANAGEMENT SERVICES

Services incident to hospitalization or confinement in a pain management center to treat or cure chronic pain.

SECTION 8.43 – LEARNING AND BEHAVIOR PROBLEMS

Hyperkinetic syndrome, learning disabilities, behavioral problems, mental retardation, or childhood autistic diseases, except ABA therapy for the treatment of autism spectrum disorder, subject to Preauthorization.

SECTION 8.44 – MEDICAL NECESSITY EXCLUSION

The fact that a physician or other provider may prescribe, order, recommend, or approve a service, supply or hospitalization does not, in itself, make it medically necessary or make the charge an allowable expense, even though it is not specifically listed as an exclusion or limitation. The Board of Trustees reserves the right to review all claims to determine if a service, supply or hospitalization is medically necessary. The Board of Trustees may limit the benefits for those services, supplies or hospitalizations which are not medically necessary.

SECTION 8.45 – PERSONAL COMFORT

Any item for personal comfort, convenience, or beautification, such as air purifiers, humidifiers, whirlpools, Jacuzzi or hot tub devices, exercise equipment, reclining chairs, bed boards, or other equipment not primarily medical in nature.

SECTION 8.46 – NO COVERAGE

Injury or illness which is sustained while the Covered Person is not covered hereunder.

SECTION 8.47 – BOTH DEPENDENT AND EMPLOYEE

Benefits payable on behalf of a Dependent previously covered under this Plan as an Employee, during a period of disability which began while the Dependent was covered as an Employee, shall not exceed the benefits that would have been payable during that period of disability had the Dependent remained covered as an Employee.

SECTION 8.48– OCCUPATIONAL THERAPY

Charges for occupational therapy performed on an Outpatient basis.

SECTION 8.49 – AUGMENTATION OR REDUCTION MAMMOPLASTY (OR MAMMAPLASTY) (unless done as a sequel to mastectomy or cancer)

SECTION 8.50 – COCCYGEAL-MENINGITIS TREATMENT

SECTION 8.51 – COLONIC LAVAGE

SECTION 8.52 – CONDOMS

SECTION 8.53 – CYTOTOXITY (CYTOTIX) TESTS

SECTION 8.54 – DIETARY SUPPLEMENTS

Including formula food, herbs, homeopathic medications, fluoride, etc. **EXCEPT** for feeding supplements to be used in conjunction with nasogastric or gastric feeding tubes.

SECTION 8.55 – DONOR COSTS FOR BLOOD

SECTION 8.56 – EXCISION, EXCESSIVE SKIN AND SUBCUTANEOUS TISSUE, INCLUDING LIPECTOMY AND LIPOSUCTION

SECTION 8.57 – EXERCISE EQUIPMENT – HAND-EXERCISE, BICYCLES, TREADMILLS, ROWING EQUIPMENT, EQUIPMENT ATTACHED TO THE HOME AND SIMILAR EQUIPMENT

SECTION 8.58 – GENIOPLASTY (chin surgery)

SECTION 8.59 – HAIR ANALYSIS

SECTION 8.60 – HAIR TRANSPLANT

SECTION 8.61 – HEAVY METAL ANALYSIS

SECTION 8.62 – INVERSION THERAPY

SECTION 8.63 – IRIDOLOGY

SECTION 8.64 – LAETRILE THERAPY

SECTION 8.65 – MASSAGE OR MASSAGE THERAPY

SECTION 8.66 – MYOFUNCTIONAL THERAPY

SECTION 8.67 – ORTHOGNATIC SURGERY

SECTION 8.68 – ORTHOMOLECULAR THERAPY

SECTION 8.69 - PLETHYSMOGRAM

SECTION 8.70 – RADIO KERATOTOMY EXCEPT FOR KERATOCONUS

SECTION 8.71 – REMOVAL OF TATTOOS

SECTION 8.72 – RHINOPLASTY (plastic surgery on the nose)

SECTION 8.73 – RHYTIDECTOMY (RHITIDECTOMY) (also known as a facelift)

SECTION 8.74 – THERMOGRAM

SECTION 8.75 – TRACE MINERAL THERAPY

SECTION 8.76 – UPPER AND LOWER BLEPHAROPLASTY (eyelid surgery)

SECTION 8.77 – BOOKS AND EDUCATIONAL MATERIALS

SECTION 8.78 – CERVICAL PILLOWS

SECTION 8.79-CHELATION THERAPY, EXCEPT FOR LEAD OR ARSENIC POISONING

SECTION 8.80 – SERVICES NOT RELATED TO CARE

Coverage shall not include medical examination, services, supplies, or tests not connected with care and treatment of an Active illness, disease, injury or condition except for those covered as medical benefits.

SECTION 8.81 – TRANSGENDER SERVICES

Any treatment, drug, service or supply related to changing sex or sexual characteristics, including surgical procedures to alter the appearance or function of the body; hormones and hormone therapy; prosthetic devices; and medical or psychological counseling will be covered if determined to be medically necessary by a licensed physician.

ARTICLE IX: MEDICARE MEDICAL BENEFITS

ANTHEM BLUE CROSS MEDICARE ADVANTAGE

A Medicare Advantage program through Anthem Blue Cross provides medical coverage to all enrolled Medicare Retired Employees. To be eligible to enroll, you must meet the eligibility requirements outlined in Section 2.08, and be eligible for Medicare Part A and enroll in Medicare Part B. Failure to meet these requirements will make you ineligible to enroll in the Anthem Blue Cross Medicare Advantage plan. In addition to the Medicare Part B premium, you are required to pay the Plan's Retiree Age 65+, Medicare self-pay rate.

Under this Anthem Medicare Advantage program, all medical coverage is provided through Anthem Blue Cross under a fully insured arrangement with no deductible and $0 copays for all Medicare covered services. Non-Medicare covered services may be subject to a copay or dollar/visit limitations. The Plan's coordination of coverage with Medicare is no longer available after March 1, 2021.

Please note that Sav-Rx provides prescription drug coverage for all participants, including Medicare Retired Employees. Also, a non-Medicare spouse will continue to receive the same coverage through the Fund until reaching Medicare eligible status based on the Schedule of Benefits shown on page 3. For a complete schedule of benefits regarding the Anthem Blue Cross Medicare Advantage plan, please contact the Plan Office at (877) 885-3753, or contact Anthem Blue Cross directly at (833) 848-8730.

As previously noted, the Anthem Blue Cross Medicare Advantage program does not require any out-of-pocket cost for Medicare covered services. In addition, the Anthem Medicare Advantage program offers other services at no cost to you, such as Nurse HelpLine, Healthy Food Deliveries, SilverSneakers®, telemedicine, and health and wellness education programs and counseling designed to manage a health condition or promote an active lifestyle. If you are not yet eligible for Medicare but would like to receive more information on the Anthem Blue Cross Medicare Advantage plan, please call Anthem Blue Cross at (833) 848-8729.

ARTICLE X: DENTAL BENEFITS (DELTA DENTAL)

A. GENERAL INFORMATION ON DENTAL BENEFIT

The Plan provides dental care through an insured arrangement with Delta Dental. The Group Number is 345. You may call Delta Dental at 800-765-6003 if you have questions.

1. **YOUR DENTAL BENEFITS:** Your dental plan covers several categories of Benefits, when the services are provided by a licensed dentist, and when they are necessary and customary under the generally accepted standards of dental practice.

2. **IMPORTANT DENTAL RULES:** If you opt to receive dental services that are not covered services under this plan, your Delta Dental Dentist may charge you his or her Usual and Customary rate for those services. Prior to providing you dental services that are not a covered Benefit, your dentist should provide you with a treatment plan that includes each anticipated service to be provided and the estimated cost of each service (see PREDETERMINATIONS). If you would like more Information about dental coverage options, you may call our Customer Service department at 800-765-6003. To fully understand your coverage, you may wish to carefully review this Evidence of Coverage document. **ALERT: Be aware of the Limitations and Exclusions in Sections F and G below.**

3. **DENTAL MAXIMUMS:** After you have satisfied any Deductible requirements, Delta Dental will provide payment for these services at the percentage Indicated up to a Maximum of $2,500 for each Enrollee In each calendar year If services are provided by a Delta Dental PPO Dentist; or $2,000 for each Enrollee In each calendar year If services are provided by any other dentist.

An agreement between your employer and Delta Dental is required to change Benefits during the term of the Contract.

The following Benefits are limited to the applicable percentages of dentist's fees or allowances specified below. You are required to pay the balance of any such fee or allowance, known as the "Enrollee copayment."

If the dentist discounts, waives or rebates any portion of the Enrollee co-payment to the Enrollee, Delta Dental only provides as Benefits the applicable allowances reduced by the amount that such fees or allowances are discounted, waived or rebated.

B. DIAGNOSTIC AND PREVENTIVE BENEFITS

90% if provided by a Delta Dental PPO Dentist
80% if provided by other dentists

Diagnostic - oral examinations; x-rays; diagnostic casts; examination of biopsied tissue; palliative (emergency) treatment of dental pain; specialist consultation

Preventive - prophylaxis (cleaning); fluoride treatment; space maintainers

Note on additional Benefits during pregnancy. If you are pregnant, Delta Dental will pay for additional services to help Improve your oral health during pregnancy, the additional services each calendar year while you are eligible in this Delta Dental plan Include: one additional oral examination and either one additional routine cleaning or one additional periodontal scaling and root planning per quadrant. Written confirmation of your pregnancy must be provided by you or your dentist when the claim is submitted.

C. BASIC BENEFITS

80% if provided by a Delta Dental PPO Dentist
80% if provided by other dentists

Oral surgery - extractions and certain other surgical procedures, including pre-and postoperative care

Restorative - amalgam, silicate or composite (resin) restorations (fillings) for treatment of carious lesions (visible destruction of hard tooth structure resulting from the process of dental decay)

Endodontic - treatment of the tooth pulp

Periodontic - treatment of gums and bones that support the teeth

Sealants - topically applied acrylic, plastic or composite material used to seal developmental grooves and pits in teeth for the purpose of preventing dental decay

Adjunctive General Services - general anesthesia; I.V. sedation; office visit for observation; office visit after regularly scheduled hours; therapeutic drug Injection; treatment of post-surgical complications (unusual circumstances); limited occlusal adjustment

D. CROWNS, INLAYS, ONLAYS AND CAST RESTORATION BENEFITS

80% if provided by a Delta Dental PPO Dentist
80% if provided by other dentists

Crowns, Inlays, Onlays and Cast Restorations are Benefits only if they are provided to treat cavities which cannot be restored with amalgam, silicate or direct composite (resin) restorations

E. PROSTHODONTIC BENEFITS

80% if provided by a Delta Dental PPO Dentist
80% if provided by other dentists

Construction or repair of fixed bridges, partial dentures and complete dentures are Benefits If provided to replace missing, natural teeth

Implant surgical placement and removal and for Implant supported prosthetics, Including implant repair and re-cementation.

F. LIMITATIONS/EXCLUSIONS FROM COVERAGE

1. An oral examination Is a Benefit only twice in a calendar year while you are eligible under any Delta Dental plan. See note on additional Benefits during pregnancy.

2. Full-mouth x-rays are Benefits once in a five year period while you are eligible under any Delta Dental plan.

3. Delta Dental pays for a panoramic x-ray provided as an individual service only after five years have elapsed since any prior panoramic x-ray was provided under any Delta Dental plan. Bitewing x-rays are provided on request by the dentist, but no more than twice In any calendar year for children to age 18 or once In any calendar year for adults age 18 and over, while you are eligible under any Delta Dental plan.

4. Delta Dental pays for two cleanings or a dental procedure that includes a cleaning each calendar year under any Delta Dental plan. If you are pregnant during this time, we may pay for an additional cleaning. See note on additional Benefits during pregnancy.

   Routine prophylaxes are covered as a Diagnostic and Preventive Benefit and periodontal prophylaxes are covered as a Basic Benefit.

5. Fluoride treatments are covered twice each calendar year under any Delta Dental plan.

6. Periodontal scaling and root planning is a Benefit once for each quadrant each 24-month period. See note on additional Benefits during pregnancy.

7. Sealant Benefits Include the application of sealants only to permanent first molars through age eight and second molars through age 15 If they are without caries (decay) or restorations on the occlusal surface. Sealant Benefits do not include the repair or replacement of a sealant on any tooth within two years of its application.

8. Crowns, Inlays, Onlays and Cast Restorations are Benefits on the same tooth only once every five years, while you are enrolled under any Delta Dental plan, unless Delta Dental determines that replacement is required because the restoration is unsatisfactory as a result of poor quality of care, or because the tooth Involved has experience extensive loss or changes to tooth structure or supporting tissues since the replacement of the restoration.

9. Prosthodontlc appliances and Implants are Benefits only once every five years, while you are eligible under any Delta Dental plan, unless Delta Dental determines that there has been such an extensive loss of remaining teeth or a change in supporting tissues that the existing appliance cannot be made satisfactory. Replacement of a prosthodontic appliance not provided under a Delta Dental plan will be made if it is unsatisfactory and cannot be made satisfactory. Delta Dental will replace an Implant, a prosthodontic appliance or an Implant supported prosthesis you received under another dental plan if we determine it is unsatisfactory and cannot be made satisfactory. We will pay for the removal of an Implant once for each tooth during the Enrollee's lifetime.

10. Delta Dental will pay the above percentage of the dentist's fee for a standard partial or complete denture. A standard partial or complete denture is one made from accepted materials and by conventional methods.

11. If you select a more expensive plan of treatment than is customarily provided, or specialized techniques, an allowance will be made for the least expensive, professionally acceptable, alternative treatment plan. Delta Dental will pay the applicable percentage of the lesser fee for the customary or standard treatment and you are responsible for the remainder of the dentist's fee.

For example: a crown where an amalgam filling would restore the tooth; or a precision denture where a standard denture would suffice.

G. EXCLUSIONS/ SERVICES NOT COVERED. Delta Dental covers a wide variety of dental care expenses, but there are some services for which we do not provide Benefits. It is Important for you to know what these services are before you visit your dentist.

Delta Dental does not provide benefits for:

1. Services for Injuries or conditions that are covered under Workers' Compensation or Employer's Liability Laws.

2. Services which are provided to the Enrollee by any Federal or State Governmental Agency or are provided without cost to the Enrollee by any municipality, county or other political subdivision, except Medi-Cal benefits.

3. Services for cosmetic purposes or for conditions that are a result of hereditary or developmental defects, such as cleft palate, upper and lower jaw malformations, congenitally missing teeth and teeth that are discolored or lacking enamel.

4. Services for restoring tooth structure lost from wear (abrasion, erosion, attrition, or abfraction), for rebuilding or maintaining chewing surfaces due to teeth out of alignment or occlusion, or for stabilizing the teeth. Examples of such treatment are equilibration and periodontal splinting.

5. Any Single Procedure, bridge, denture or other prosthodontic service which was started before the Enrollee was covered by this plan.

6. Prescribed drugs, or applied therapeutic drugs, premedication or analgesia.

7. Experimental procedures.

8. Charges by any hospital or other surgical or treatment facility and any additional fees charged by the Dentist for treatment in any such facility.

9. Anesthesia, except for general anesthesia or I.V. sedation given by a licensed Dentist for Oral Surgery services and select Endodontic and Periodontic procedures.

10. Grafting tissues from outside the mouth to tissues inside the mouth (“extraoral grafts”).

11. Diagnosis or treatment by any method of any condition related to the temporomandibular (jaw) joints or associated muscles, nerves or tissues.

12. Replacement of existing restoration for any purpose other than active tooth decay.

13. Occlusal guards and complete occlusal adjustment.

14. Orthodontic services (treatment of mal-alignment of teeth and/or jaws).

H. **DEDUCTIBLE.** You must pay the first $25 of Covered Services for each Enrollee In your family in each calendar year.

I. **OTHER CHARGES.** Delta Dental's co-payment for your Benefits is shown in this Evidence of Coverage under the caption titled “YOUR BENEFITS.” If dental services are provided by a Delta Dental Dentist or a Delta Dental PPO Dentist, you are responsible for your co-payment only. If the dental services you receive are provided by a dentist who is not a Delta Dental Dentist or Delta Dental PPO Dentist, you are responsible for the difference between the amount Delta Dental pays and the amount charged by the non-Delta Dental dentist.

J. **COVERED FEES.** It is to your advantage to select a dentist who is a Delta Dental Dentist, since a lower percentage of the dentist's fees may be covered by this plan If you select a dentist who Is not a Delta Dental Dentist.

A list of Delta Dental Dentists (see DEFINITIONS) is available using our website - deltadentalins.com, or by calling (800) 765-6003.

Payment to a Delta Dental PPO Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, the dentist's accepted Usual, Customary and Reasonable Fee on file with Delta Dental, or a fee which the dentist has contractually agreed upon with Delta Dental to accept for treating enrollees under this plan.

Payment to a Delta Dental Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the accepted Usual, Customary and Reasonable fee that the dentist has on file with Delta Dental.

Payment for services by a California dentist, or an out-of-state dentist, who is not a Delta Dental Dentist will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the fee that satisfies the majority of Delta Dental Dentists.

Payment for services by a dentist located outside the United States will be based on the applicable percentage of the lesser of the Fee Actually Charged, or the fee that satisfies the majority of Delta Dental dentists.

K. CHOICE OF DENTISTS AND PROVIDERS

PLEASE READ THE FOLLOWING INFORMATION SO YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS HEALTH CARE MAY BE OBTAINED.

Nearly 29,000 dentists in active practice In California are Delta Dental Dentists. About 16,500 of these Delta Dental Dentists are also Delta Dental PPO Dentists. While covered under the PPO plan, you are free to choose any dentist for treatment, but It Is to your advantage to choose a Delta Dental Dentist. This is because his or her fees are approved In advance by Delta Dental. Delta Dental Dentists have treatment forms on hand and will complete and submit the forms to Delta Dental free of charge.

If you choose a Delta Dental PPO Dentist, you will receive all of the advantages of going to a Delta Dental Dentist, and you may have a higher level of Benefits for certain services.

If you go to a non-Delta Dental Dentist, Delta Dental cannot assure you what percentage of the charged fee may be covered. Claims for services from non-Delta Dental Dentists may be submitted to Delta Dental at P.O. Box 997330, Sacramento, CA 95899-7330.

Dentists located outside the United States are not Delta Dental Dentists. Claims submitted by out-of-country dentists are translated by Delta Dental staff and the currency is converted to U.S. dollars. Claims submitted by out-of-country dentists for Enrollees residing In California are referred to Delta Dental's Quality Assessment department for processing. Delta Dental may require a clinical examination to determine the quality of the services provided, and Delta Dental may decline to reimburse you for Benefits if the services are found to be unsatisfactory.

A list of Delta Dental PPO Dentists and Delta Dental Dentists can be obtained by calling (800) 765 -6003. This list will identify those dentists who can provide care for Individuals who have mobility Impairments or have special health care needs. You can also obtain specific Information about Delta Dental PPO Dentists and Delta Dental Dentists by using the website - deltadentallns.com or calling the Delta Dental Customer Service department at (800) 765-6003.

Services may be obtained from any licensed dentist during normal office hours. Emergency services are available in most cases through an emergency telephone exchange maintained by the local dental society listed in the local telephone directory.

Services from dental school clinics may be provided by students of dentistry or Instructors who are not licensed by the state of California.

Delta Dental shares the public and professional concern about the possible spread of HIV and other infectious diseases in the dental office. However, Delta Dental cannot ensure your dentist's use of precautions against the spread of such diseases, or compel your dentist to be tested for HIV or to disclose test results to Delta Dental, or to you. Delta Dental informs its panel dentists about the need for clinical precautions as recommended by recognized health authorities on this Issue. If you should have questions about your dentist's health status or use of recommended clinical precautions, you should discuss them with your dentist.

L. CONTINUITY OF CARE

1. **Current Enrollees.** Current Enrollees may have the right to the benefit of completion of care with their terminated Delta Dental Dentist for certain specified dental conditions. Please call Delta Dental's Quality Assessment Department at (415) 972-8300 to see if you may be eligible for this benefit. You may request a copy of the Delta Dental's Continuity of Care Policy. You must make a specific request to continue under the care of your terminated Delta Dental Dentist. We are not required to continue your care with that dentist if you are not eligible under our policy or If we cannot reach agreement with your terminated Delta Dental Dentist on the terms regarding your care In accordance with California law.

2. **New Enrollees.** A new Enrollee may have the right to the qualified benefit of completion of care with their non-Delta Dental Dentist for certain specified dental conditions. Please call Delta Dental's Quality Assessment Department at (415) 972-8300 to see if you may be eligible for this benefit. You may request a copy of the Delta Dental's Continuity of Care Policy. You must make a specific request to continue under the care of your current provider. We are not required to continue your care with that dentist If you are not eligible under our policy or if we cannot reach agreement with your non-Delta Dental Dentist on the terms regarding your care In accordance with California law. This policy does not apply to new Enrollees of an Individual subscriber contract.

M. PUBLIC POLICY PARTICIPATION BY ENROLLEES. Delta Dental's Board of Directors includes Enrollees who participate in establishing Delta Dental's public policy regarding Enrollees through periodic review of Delta Dental's Quality Assessment program reports and communication from Enrollees. Enrollees may submit any suggestions regarding Delta Dental's public policy in writing to: Delta Dental of California, Customer Service Department, P.O. Box 997330, Sacramento, CA 95899-7330.

N. SAVING MONEY ON YOUR DENTAL BILLS. You can keep your dental expenses down by practicing the following:

1. Compare the fees of different dentists;

2. Use a Delta Dental Dentist;

3. Have your dentist obtain predetermination from Delta Dental for any treatment over $300;

4. Visit your dentist regularly for checkups;

5. Follow your dentist's advice about regular brushing and flossing;

6. Avoid putting off treatment until you have a major problem; and

7. Learn the facts about overbilling. Under this plan, you must pay the dentist your co-payment share (see YOUR BENEFITS). You may hear of some dentists who offer to accept insurance payments as “full payment.” You should know that these dentists may do so by overcharging your plan and may do more work than you need, thereby increasing plan costs. You can help keep your dental Benefits Intact by avoiding such schemes.

O. **ACCESSIBILITY AND SERVICES FOR AFTER HOURS AND URGENT CARE.** If you or a family member has special needs, you should ask your dentist about accessibility to their office or clinic at the time you call for an appointment. Your dentist will be able to tell you if their office is accessible taking into consideration the specific requirements of your needs.

Routine or urgent care may be obtained from any licensed dentist during their normal office hours. Delta Dental does not require prior authorization before seeking treatment for urgent or after-hours care. You may plan In advance, for treatment for urgent, emergency or after-hours care by asking your dentist how you can contact the dentist in the event you or a family member may need urgent care treatment or treatment after normal business hours. Many dentists have made prior arrangements with other dentists to provide care to you if treatment is immediately or urgently needed. You may also call the local dental society that is listed in your local telephone directory if your dentist is not available to refer you to another dentist for urgent, emergency or after-hours care.

P. **YOUR FIRST APPOINTMENT.** During your first appointment, be sure to give your dentist the following information:

1. Your Delta Dental group number (on the front of this booklet);

2. The employer's name;

3. Primary Enrollee's ID number (which must also be used by Dependents);

4. Primary Enrollee's date of birth;

5. Any other dental coverage you may have.

Q. **PREDETERMINATIONS.** After an examination, your dentist will talk to you about treatment you may need. The cost of treatment is something you may want to consider. If the service is extensive and involves crowns or bridges, or if the service will cost more than $300, we encourage you to ask your dentist to request a predetermination.

A predetermination does not guarantee payment. It is an· estimate of the amount Delta Dental will pay If you are eligible and meet all the requirements of your plan at the time the treatment you have planned is completed.

In order to receive predetermination, your dentist must send a claim form listing the proposed treatment. Delta Dental will send your dentist a Notice of Predetermination which estimates how much you will have to pay. After you review the estimate with your dentist and decide to go ahead with the treatment plan, your dentist returns the form to us for payment when treatment has been completed.

Computations are estimates only and are based on what would be payable on the date the Notice of Predetermination is issued if the individual is eligible. Payment will depend on the Individual's eligibility and the remaining annual Maximum when completed services are submitted to Delta Dental.

Predetermining treatment helps prevent any misunderstanding about your financial responsibilities. If you have any concerns about the predetermination, let us know before treatment begins so your questions can be answered before you incur any charges.

R. REIMBURSEMENT PROVISIONS. A Delta Dental Dentist will file the claim for you. You do not have to file a claim or pay Delta Dental's co-payment for covered services if provided by a Delta Dental Dentist. Delta Dental of California's agreement with our Delta Dental Dentists makes sure that you will not be responsible to the dentist for any money we owe.

If the covered service is provided by a dentist who is not a Delta Dental Dentist, you are responsible for filing the claims and paying your dentist. Claims should be filed with Delta Dental of California at P.O. Box 997330, Sacramento, CA 95899-7330 and Delta Dental will reimburse you. However, if for any reason we fail to pay a dentist who is not a Delta Dental Dentist, you may be liable for that portion of the cost. Payments made to you are not assignable (In other words, we will not grant requests to pay non-Delta Dental Dentists directly).

Payment for claims exceeding $500 for services provided by dentists located outside the United States may, at Delta Dental's option, be conditioned upon a clinical evaluation at Delta Dental's request (see Second Opinions). Delta Dental will not pay Benefits for such services if they are found to be unsatisfactory.

Delta Dental does not pay Delta Dental Dentists any incentive as an Inducement to deny, reduce, limit or delay any appropriate service. If you wish to know more about the method of reimbursement to Delta Dental Dentists, you may call Delta Dental's Customer Service department for more Information.

Payment for any Single Procedure that Is a Covered Service will only be made upon completion of that procedure. Delta Dental does not make or prorate payments for treatment in progress or incomplete procedures. The date the procedure is completed governs the calculation of any Deductible (and determines when a charge is made against any Maximum) under your plan.

If there is a difference between what your dentist is charging you and what Delta Dental says your portion should be, or if you are not satisfied with the dental work you have received, contact Delta Dental's Customer Service department. We may be able to help you resolve the situation.

Delta Dental may deny payment of a claim for services submitted more than 12 months after the date the services were provided. If a claim is denied due to a Delta Dental Dentist's failure to make a timely submission, you shall not be liable to that dentist for the amount which would have been payable by Delta Dental (unless you failed to advise the dentist of your eligibility at the time of treatment).

The process Delta Dental uses to determine or deny payment for services is distributed to all Delta Dental Dentists. It describes in detail the dental procedures covered as Benefits, the conditions under which coverage is provided, and the limitations and exclusions applicable to the plan. Claims are reviewed for eligibility and are paid according to these processing policies. Those claims which require additional review are evaluated by Delta Dental's dentist consultants. If any claims are not covered, or if limitations or exclusions apply to services you have received from a Delta Dental Dentist, you will be notified by an adjustment notice on the Notice of Payment or Action. You may contact Delta Dental's Customer Service department for more information regarding Delta Dental's processing policies.

Delta Dental uses a method called “first-in/first-out” to begin processing your claims. The date we receive your claim determines the order in which processing begins. For example, if you receive dental services in January and February, but we receive the February claim first, processing begins on the February claim first.

Incomplete or missing data can affect the date the claim is paid. If you or your dentist has not provided Delta Dental with all information necessary to complete claim processing, payment could be delayed until any missing or incomplete data is received by Delta Dental.

Unless the services are exempt, you are required to pay the Deductible on the first claim for which processing is completed in a calendar year. Your Deductible Is normally paid on the first service subject to a deductible listed on a claim with multiple services.

The order in which your claims are processed and paid by Delta Dental may also impact your annual Maximum. For example, if a claim with a later date of service is paid and your annual Maximum for the year has been reached then a claim with an earlier date of service In the same calendar year will not be paid.

Maximums can also be affected when the amount paid for services provided by Delta Dental PPO Dentists is higher than the maximum paid for services provided by a dentist who is not a Delta Dental PPO dentist. For example, if the Delta Dental PPO Plan's annual Maximum is $1,200 and the maximum for services provided by a dentist who is not a Delta Dental PPO dentist is $1,000 and Delta Dental has paid $1,000 or more dollars for covered dental services, you do not qualify for any further payments for services provided by a dentist who is not a Delta Dental PPO dentist. But, if any other covered services are provided by a Delta Dental PPO Dentist, you qualify for an additional $200.

S. **IF YOU HAVE QUESTIONS ABOUT SERVICES FROM A DELTA DENTAL DENTIST.** If you have questions about the services you receive from a Delta Dental Dentist, we recommend that you first discuss the matter with your dentist. If you continue to have concerns, call our Quality Assessment department at (415) 972-8300, extension 2700. If appropriate, Delta Dental can arrange for you to be examined by one of our consulting dentists in your area. If the consultant recommends the work be replaced or corrected, Delta Dental will Intervene with the original dentist to either have the services replaced or corrected at no additional cost to you or obtain a refund. In the latter case, you are free to choose another dentist to receive your full Benefit.

T. **SECOND OPINIONS.** Delta Dental obtains second opinions through Regional Consultant members of its Quality Review Committee who conduct clinical examinations, prepare objective reports of dental conditions, and evaluate treatment that is proposed or has been provided.

Delta Dental will authorize such an examination prior to treatment when necessary to make a Benefits determination in response to a request for a Predetermination of treatment cost by a dentist. Delta Dental will also authorize a second opinion after treatment if an Enrollee has a complaint regarding the quality of care provided. Delta Dental will notify the Enrollee and the treating dentist when a second opinion is necessary and appropriate, and direct the Enrollee to the Regional Consultant selected by Delta Dental to perform the clinical examination. When Delta Dental authorizes a second opinion through a Regional Consultant, we will pay for all charges.

Enrollees may otherwise obtain second opinions about treatment from any dentist they choose, and claims for the examination may be submitted to Delta Dental for payment. Delta Dental will pay such claims in accordance with the Benefits of the plan.

For details on your benefit coverage, please refer to the Delta Dental's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its participants.

ARTICLE XI: VISION CARE BENEFITS

The Plan provides vision care benefits through Vision Service Plan (("VSP") www.vsp.com. The phone number is (800) 877-7195. A separate booklet, which you should have is, available that the Plan Office with complete benefit coverage, limitations and exclusions.

Vision Services Plan (VSP)
101 California Street, Suite 975
San Francisco, CA 94111

Member Services: http://www.vsp.com
(800) 877-7195
(800) 428-4833 (toll-free TTY for the hearing/speech impaired)

The Vision Service Plan (VSP) covers each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction.

1. **To obtain services:** To obtain services of a Panel Doctor, an eligible Participant and/or Dependent is requested to contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member and the group name. The doctor's office will verify eligibility and benefits. **If you need to locate a VSP participating doctor, call VSP at (800) 877-7195, or find one at www.vsp.com.**

VSP will pay the doctor directly. There is no ID card necessary but if you would like a card as a reference, you may print out one at vsp.com. Except as otherwise provided in this section, you are responsible only for the applicable co-payment **and any additional costs for items only partially covered or not covered. No co-payment applies for contacts**.

If you use a doctor from the VSP network, this assures direct payment to the doctor and guarantees quality and cost control; however, if you decide to use the services of a doctor who is not a VSP Panel Member, you should pay the doctor his or her fee. You will later be reimbursed in accordance with the VSP reimbursement schedule by VSP. **ALERT: Be aware of the smaller reimbursements if you obtain your vision care benefits at a non-network provider as set forth in Section 6 below.**

2. **Services and Materials:**

a. **One Vision Examination per Calendar Year.** The Plan provides for a comprehensive examination of your visual functions once every calendar year, including the prescription of corrective eyewear where indicated.

b. **Lenses and Frames.** If the vision examination indicates that new lenses or frames for both are necessary for the proper visual health of a covered person, the Plan provides:

(1) Lenses - Actives: **available** every calendar year, if a prescription change is warranted, Single vision, lined bifocal and lined trifocal lenses are covered. Poly carbonate lenses are available for dependent children.

- Standard progressive lenses $55
- Premium progressive lenses $95-105
- Custom progressive lenses $150-175
- Average savings of 30% on other lens enhancements

(2) Frames - Actives: Valid every other calendar year if replacement is necessary; there is a $150 allowance for a wide selection of frames. There is a $170 allowance for featured brands.

3. **Contact Lenses Care:** When you choose contacts instead of glasses, there is a $150 allowance and the co-pay does not apply. There is an allowance of up to $60 for a contact lens exam (fitting and evaluation) once every calendar year.

4. **Extra Discounts and Savings:**

   a. **Prescription Glasses.** Up to 20% savings on lens extras such as scratch resistant and anti-reflective coating and progressives. 20% discount on additional prescription glasses and sunglasses.

   b. **Contacts.** 15% off cost of contact lens exam (fitting and evaluation) available from the same VSP doctor who provided your eye exam within the last 12 months.

5. **Your Co-Pays (subject to change):**

Exam	$15
Prescription Glasses	$ 25
Contacts	No co-pay

6. **Out-of-Network (Non-VSP) Smaller Reimbursement.** If you choose to receive vision care services and materials from a doctor who is not a panel member of VSP or from a dispensing optician, you will be reimbursed in accordance with the following schedule:

(1)	**Professional Fees**	Vision Examination, up to	$ 45
(2)	**Materials**	Single Vision Lenses, up to	$ 30
	Lens	Lined Bifocal Lenses, up to	$ 50
	(Choice of one; once per-calendar Year)	Lined Trifocal Lenses, up to	$ 65
(3)	**Contact Lenses**	Frames, up to	$ 70
	(other than cosmetic contact lenses)	Up to	$105
(4)	**Progressive Lens**	Up to	$50

These amounts may change at any time. Please call VSP for vision care request forms at (800) 877-7195 prior to visiting your provider or at www.vsp.com.

7. **VSP Grievance Procedures:** If a Participant has a complaint/grievance (hereafter 'grievance') regarding VSP service or claim payment, the Participant may communicate the grievance to VSP by using the form which is available by calling VSP Customer Service Department's toll-free number (800) 877-7195 Monday through Friday 6:00 a.m. to 6:00 p.m. Pacific Standard Time. Grievances may be filed in writing within 180 days with VSP at 3333 Quality Drive, Rancho Cordova, CA 95670.

   If you are dissatisfied with the results after exhausting VSP's grievance procedures, you may file a written appeal with the Plan's Board of Trustees, as provided in the Claims and Appeals Procedures.

   The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans and receiving complaints regarding VSP (and similar programs). If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by VSP, you may call the Department's help center toll-free at (888) 466-2219. The hearing and speech impaired may use the California Relay Service's toll-free telephone numbers to contact the Department by dialing 711 (within California), or as follows:

Type of Call	Language	Toll-free 800 Number
TTY/VCO/HCO to Voice	English Spanish	1-800-735-2929 1-800-855-3000
Voice to TTY/VCO/HCO	English Spanish	1-800-735-2922 1-800-855-3000
From or to Speech-to- Speech	English & Spanish	1-800-854-7784

Plan complaint forms and instructions are available online at the Department's website, http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_complaint.aspx.

NOTE: VSP's grievance process and the Department's complaint review process are in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law.

ARTICLE XII: COORDINATION OF BENEFITS WITH OTHER PLANS (COB)

All benefits of this Plan are subject to Coordination of Benefits (COB) provided, however, COB payment amounts shall not exceed the contracted maximums of the contract providers.

SECTION 11.01 – PURPOSE

The intent of this Article is to guarantee that the amount of benefits paid under this Plan plus the amounts of benefits paid under all other plans shall not exceed the actual cost charged for a treatment or service.

SECTION 11.02 – DEFINITIONS

1. **COORDINATION -** shall mean benefits are paid so that no more than 100% of the Network Allowance shall be covered under the combined benefits from all of the plans shown in paragraph 2 below.

2. **PLAN -** shall mean any medical expense benefits provided under:

a. any insured or non-insured group, service, prepayment, or other program arranged through an Employer, Trustee, union, or association; or

b. any program required or established by state or federal law; or

c. any program sponsored by or arranged through a school or other educational agency; and the first party medical expense provisions of any automobile policy issued under a no-fault insurance statute including the self-insured equivalent or any minimum benefits required by law except that the term Plan shall not include benefits provided under a student accident policy or any individual policy, nor shall the term Plan include benefits provided under a state medical assistance program where eligibility is based on financial need.

The term Plan shall apply separately to those parts of any program that contain provisions for coordination of benefits with other plans and separately to those parts of any program which do not contain such provisions.

3. **ALLOWABLE EXPENSE -** shall mean all Prevailing Charges for treatment or service when at least a part of those charges are covered under at least one of the Plans then in force for the Covered Person for whom benefits are claimed.

4. **CLAIM DETERMINATION PERIOD -** shall mean the part of a calendar year during which a Covered Person would receive benefit payments under this Plan if this Article were not in force.

SECTION 11.03 – EFFECT ON BENEFITS

Benefits otherwise payable under this Plan for Allowable Expenses during a Claim Determination Period shall be reduced if:

1. benefits are payable under any other Plan for the same Allowable Expenses; and

2. the rules listed in Section 10.04 below provide that benefits payable under the other Plan are to be determined before the benefits payable under this Plan.

The reduction shall be the amount needed to provide that the sum of payments under this plan plus benefits payable under the other Plan(s) is not more than the total of Allowable Expenses. Each benefit that would be payable in the absence of this Article shall be reduced proportionately; any such reduced amount shall be charged against any applicable benefit limit of this Plan.

For this purpose, benefits payable under other Plans shall include the benefits that would have been paid had claim been made for them.

SECTION 11.04 – ORDER OF BENEFIT DETERMINATION

Except as described in Section 10.05 below, the benefits payable of a Plan that does not have a coordination of benefits provision substantially similar to the provision described in this Article shall be determined before the benefits payable of a Plan that does have such a provision. In all other instances, the order of determination shall be:

1. EMPLOYEE vs. DEPENDENT / PRIMARY vs. SECONDARY. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee (other than as a Dependent) are determined before the benefits of a Plan which covers the person as a Dependent.

2. DEPENDENT CHILD - PARENTS NOT SEPARATED OR DIVORCED (Birthday rule). Except as stated in Paragraph 3 below, when this Plan and another Plan cover the same child as a Dependent of different persons, called "parents," the benefits of the Plan of the parent whose birthday falls earlier in a calendar year are determined before those of the Plan of the parent whose birthday falls later in that year; but if both parents have the same birthday, the benefits of the Plan which covered the parent longer are determined before those of the Plan which covered the other parent for a shorter period of time.

   If, however, another Plan does not have the rule described in Paragraph 2 above, but instead has a rule based on the gender of the parent, and if, as a result, the Plans do not agree on the order of benefits, the rule in the other Plan shall determine the order of benefits.

3. DEPENDENT CHILD - SEPARATED OR DIVORCED PARENTS. If two or more Plans cover a Dependent child of divorced or separated parents, benefits for the child are determined in this order:

   a. first, the Plan of the parent with custody of the child;

   b. then, the Plan of the spouse of the parent with custody of the child; and

   c. finally, the Plan of the parent not having custody of the child.

   If there is joint physical custody of the children, coverage will default to the patient who claims the dependent on his or her tax return. (This means that if the parties rotate claiming a child on their tax returns, coverage will also rotate.)

   If, however, the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the entity obligated to pay or provide the benefits of the Plan of that parent has actual knowledge of those terms, the benefits of that Plan are determined first. This paragraph does not apply with respect to any Claim Determination Period or Plan Year during which any benefits are actually paid or provided before the entity has that actual knowledge.

4. OTHER DEPENDENT CHILDREN. This Plan shall always pay secondary to any other group type coverage.

5. ACTIVE/INACTIVE EMPLOYEE. The benefits of a Plan which covers the person for whom benefits are claimed as an Employee who is neither laid off nor retired, or as that Employee's Dependent, are determined before the benefits of a Plan which covers that person as a laid off or Retired Employee or as that Employee's Dependent. If the other Plan does not have this rule, and if, as a result, the Plans do not agree on the order of benefits, this rule shall not apply.

6. LONGER/SHORTER LENGTH OF COVERAGE. If none of the above rules determine the order of benefits, the benefits of the Plan which covered the person for whom benefits are claimed longer are determined before those of the Plan which covered that person for the shorter time.

7. DEPENDENTS OF DECEASED ACTIVE EMPLOYEES. This Plan shall always pay secondary to any other group type coverage.

SECTION 11.05 – EXCHANGE OF INFORMATION

Any Covered Person who claims benefits under this Plan shall, upon request, provide all information the Trust believes is needed to coordinate benefits as described in this Article.

All information the Trust believes is needed to coordinate benefits shall be exchanged with other plans, companies, organizations, or persons.

SECTION 11.06 – FACILITY OF PAYMENT

The Trust may reimburse any other Plan if benefits were paid by that other Plan, but should have been paid under this Plan in accordance with this Article.

In such event, the reimbursement amounts shall be considered benefits paid under this Plan and, to the extent of those payments, shall discharge the Trust from liability.

ARTICLE XIII: CLAIMS AND APPEAL PROCEDURE

The Board of Trustees has established the claims and appeal procedures with the intent of complying with regulations issued by the Department of Labor ("DOL"). The Plan seriously takes into consideration of abiding by the claims and appeal procedure.

The following procedures apply to the Eligibility Provisions and Indemnity Plan Benefits included in this booklet. They also apply to Dental, Vision & Life Insurance claims only after the Member has exhausted the appeal procedures that are available through the respective carriers. For HMO, Dental, Vision, Life Insurance or AD&D Claims, please refer to the claims procedures in the Supplemental Summaries available in the Plan Office.

A. HOW TO FILE A CLAIM

Claims are paid in accordance with bills and forms supplied by hospitals and attending physicians. A claim shall be considered to have been filed as soon as it is received by the Plan Office at its principal office provided it is substantially complete, with all necessary documentation. If the form is not substantially complete or if required documentation has not been furnished, the claimant will be notified as soon as reasonably possible of what is necessary to complete the claim. Effective April 1, 2018, claims must be filed within 12 months from the date of treatment. Have your Physician forward claims directly to the Trust Fund Office. In certain circumstances, the time frame for submitting your claim may be extended (or delayed) under contractual requirements that may exist between Anthem Blue Cross and a Preferred Provider, Medicare or other organization. Specifically, the time period in such cases may be extended where a contract provider, Medicare or other organization has an agreement that allows for a longer period to file a claim with the Trust and the contract provider, Medicare or other organization can demonstrate with satisfactory proof that the claim submission date complies with the terms of its respective agreements and/or law.

Retiree members and their dependents that are eligible for Medicare should have the hospital and doctors submit claims to Medicare first. After Medicare has made a payment, a copy of the Medicare Explanation of Benefits Worksheet should then be submitted with a claim to the Plan Office for processing.

B. CLAIMS AND APPEALS PROCEDURES

1. DEFINITIONS

a. Adverse Benefit Determination. An "Adverse Benefit Determination" is any denial, reduction, termination of or failure to provide or make payment for a benefit (either in whole or in part) under the Plan. Each of the following is an example of an Adverse Benefit Determination:

(i) a payment of less than 100% of a Claim for benefits (including coinsurance or co-payment amounts of less than 100% and amounts applied to the deductible);

(ii) a denial, reduction, termination of or failure to provide or make payment for a benefit (in whole or in part) resulting from any utilization review decision;

(iii) a failure to cover an item or service because the Plan considers it to be Experimental, Investigational, not Medically Necessary or not Medically Appropriate;

(iv) a restriction on reimbursement for particular services because they are classified as related to a mental or nervous, rather than a physical, condition; and

(v) a decision that denies a benefit based on a determination that a claimant is not eligible to participate in the Plan.

Presentation of a prescription order at a pharmacy, where the pharmacy refuses to fill the prescription unless the Participant pays the entire cost, is not considered an Adverse Benefit Determination (but only to the extent that the pharmacy's decision for denying the prescription is based on coverage rules predetermined by the Plan).

b. **Claim.** The term "Claim" means a request for a benefit made by a Participant in accordance with the Plan's reasonable procedures.

Casual inquiries about benefits or the circumstances under which benefits might be paid are not considered Claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a Claim. However, if a Participant files a Claim for specific benefits and the Claim is denied because the individual is not eligible under the terms of the Plan, that coverage determination is considered a Claim.

The presentation of a prescription order at a pharmacy does not constitute a Claim, to the extent benefits are determined based on cost and coverage rules predetermined by the Plan. If a Physician, Hospital or pharmacy declines to render services or refuses to fill a prescription unless the Participant pays the entire cost, the Participant should submit a Post-Service Claim for the services or prescription, as described under Claim Procedures, below.

A request for precertification or prior authorization of a benefit that does not require precertification or prior authorization by the Plan is not considered a Claim. However, requests for precertification or prior authorization of a benefit where the Plan does require precertification or prior authorization are considered Claims and should be submitted as Pre-Service Claims (or Urgent Claims, if applicable), as described under Claim Procedures, below.

Claims are categorized as Follows:

(i) Urgent Claim. The term "Urgent Claim" means a Claim for medical care or treatment that, if normal Pre-Service standards for rendering a decision were applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a Physician with knowledge of the claimant's medical condition, would subject the claimant to severe pain that could not be adequately managed without the care or treatment that is the subject of the Claim.

(ii) Pre-Service Claim. The term "Pre-Service Claim" means a Claim for a benefit for which the Plan requires precertification or prior authorization before medical care is obtained in order to receive the maximum benefits allowed under the Plan.

(iii) Concurrent Claim. The term "Concurrent Claim" means a Claim that is reconsidered after an initial approval has been made that results in a reduction, termination or extension of the previously approved benefit.

(iv) Post-Service Claim. The term "Post-Service Claim" means a Claim for benefits that is not a Pre-Service, Urgent or Concurrent Claim. This will generally be a claim for ' reimbursement for services already rendered.

(v) Disability Claims. The term "Disability Claim" means any Claim that requires a finding of Total Disability as a condition of eligibility.

c. Relevant Documents. "Relevant Documents" include documents pertaining to a Claim if they were relied upon in making the benefit determination, were submitted, considered or generated in the course of making the benefit determination, demonstrate compliance with the administrative processes and safeguards required by the regulations, or constitute the Plan's policy or guidance with respect to the denied treatment option or benefit. Relevant Documents could include specific Plan rules, protocols, criteria, rate tables, fee schedules or checklists and administrative procedures that prove that the Plan's rules were appropriately applied to a Claim.

2. NOTICE OF CLAIM DENIAL

If a claim is wholly or partially denied, the claimant shall receive a written notice of denial as follows:

a. Contents of Notice. The **notice of denial for non-disability claims** shall contain the following, written in a manner calculated to be understood by the claimant:

(i) The specific reason or reasons for the denial;

(ii) Specific reference to pertinent Plan provisions on which the denial is based;

(iii) A description of any additional material or information necessary for the claimant to perfect the claim and an explanation of why such material or information is necessary; and

(iv) Appropriate information as to the steps to be taken if the claimant wishes to submit the claim for review.

For **Denial of Disability claims**, the denial notice will contain the following:

(i) Specific reference to pertinent Plan provisions on which the denial is based;

(ii) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);

(iii) Statement that you have the right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records and other information to your claim for benefits;

(iv) Statement of your right to present evidence and testimony in support of your claim during the appeal/review process;

(v) Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

(vi) If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;

(vii) Statement that on appeal, you will have the right to respond to the denial if the Plan receives new or additional evidence and you will also be provided, free of charge, with any new or additional evidence considered as soon as it becomes available to the Plan and sufficiently in advance of the date on which the appeal determination notice is required to be provided to you under the Plan's rules. (This will usually be before the next regularly scheduled meeting of the Board of Trustees unless special circumstances requires a further extension of time); and

(viii) If applicable, notice will be provided in a culturally and linguistically appropriate manner in the predominant non-English language spoken where you live.

b. **Time of Notice.** To assure that you are eligible for medical or hospital benefits, you should call or have your physician /hospital call the Plan Office to pre-certify your eligibility for benefits. In the event that you do not obtain precertification and the Plan Office determines that a claim is not covered for any reason, you will be notified of a claim denial:

c. **Urgent Care.** In the event the claim involves "urgent care," which is defined as any claim for medical care or treatment which in your physician's opinion is required immediately to avoid jeopardizing your life, health or ability to regain maximum function, you will be notified within twenty-four (24) hours of the submission of the claim, if the information necessary to process the claim is incomplete, and/or within seventy-two (72) hours in the event coverage is denied.

d. **Pre-Service Claims.** A Pre-Service Claim is a Claim for a benefit for which the Plan requires precertification or prior authorization before medical care is obtained as a condition of receiving maximum benefits allowed under the Plan. Under the terms of this Plan, claimants are not required to obtain precertification for any services.

e. **Concurrent Claims.** Any request by a Participant to extend an approved Urgent Claim will be acted upon by the Plan within 24 hours of receipt of the Claim, provided the Claim is received at least 24 hours prior to the expiration of the approved Urgent Claim. A request to continue a Plan of treatment that is in progress that does not involve an Urgent Claim will be decided in enough time to request an appeal and to have the appeal decided before the benefit is reduced or terminated.

f. **Post-Service Claims.** A Post-Service Claim must be submitted to the Trust Fund Office in writing, using an appropriate claim form, as soon as possible after expenses are incurred. A claim form may be obtained by contacting the Trust Fund Office. Failure to file a Post-Service Claim within the time required will not invalidate or reduce any Claim if it was not reasonably possible to file the Claim within such time; however, in that case, the Claim must be submitted as soon as reasonably possible, but in no event later than one year from the date the charges were incurred.

The claim form must be completed in full and an itemized bill(s) must be attached to the claim form in order for the request for benefits to be considered a Claim. The claim form and/or itemized bill(s) must include any information requested by the Plan Office.

A Post-Service Claim is considered to have been filed upon receipt of the Claim by the Plan Office.

Ordinarily, Participants will be notified of decisions on Post-Service Claims within 30 days from the receipt of the Claim by the Plan Office. The Plan may extend this period one time for up to 15 days if the extension is necessary due to matters beyond the control of the Plan. If an extension is necessary, the Participant will be notified, before the end of the initial 30-day period of the circumstances requiring the extension and the date by which the Plan expects to render a decision.

If an extension is required because the Plan needs additional information from the Participant, the Plan will issue a Request for Additional Information that specifies the information needed. The Participant will have 45 days from receipt of the notification to supply the additional information. If the information is not provided within that time, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal deadline for making a decision on the Claim will be suspended. The deadline is, suspended from the date of the Request for Additional Information until either 45 days or until the date the Participant responds to the request, whichever is earlier. The Plan then has 15 days to make a decision on the Claim and notify the Participant of the determination.

If the Plan determines that additional information is required from the Participant, and the Participant fails to provide any requested information within 45 days, the Plan will issue a Notice of Adverse Benefit Determination.

g. **Disability Claim.** A Disability Claim must be submitted to the Plan Office within 90 days after the date of the onset of the disability. The Plan will make a decision on the Disability Claim and notify the Participant of the decision within 45 days after receipt of the Claim by the Plan Office. If the Plan requires an extension of time due to matters beyond the control of the Plan, the Trust Fund Office will notify Participant of the reason for the delay and the date by which the Plan expects to render a decision. This notification will occur before the expiration of the initial 45-day period. The notice of extension will explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the claim, and the additional information needed to resolve those issues.

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

If an extension is needed because the Plan needs additional information from the Participant, the extension notice will specify the information needed. If the information is not provided within the 45-day period, the Claim will be denied. During the 45-day period in which the Participant is allowed to supply additional information, the normal period for making a decision on the Claim will be suspended. The period for making the determination is suspended from the date of the extension notice until the earlier of: (1) 45 days from the date of the notification; or (2) the date the Participant responds to the request. Once the Participant responds to the Plan's request for the information, the Participant will be notified of the Plan's decision on the Claim within 30 days.

For Disability Claims, the Plan reserves the right to have a Physician examine the claimant (at the Plan's expense) as often as is reasonable while a claim for benefits is pending. A retroactive rescission (meaning cancellation or discontinuance) of your disability benefit coverage will be considered an adverse benefit determination that would trigger the Plan's appeals procedures. However, if the retroactive rescission was due to a failure to timely pay required premiums or contributions toward the cost of coverage that would not be considered an adverse benefit determination.

If the Plan has failed to comply with the claims and appeals procedure requirements for disability claims, you will not be prohibited from filing suit or seeking court review of a claim denial based on a failure to exhaust the administrative remedies under the Plan unless the violation was the result of a minor error or considered "de minimis." This would mean: (a) non-prejudicial, (b) attributable to good cause or matters beyond the Plan's control, (c) in the context of an ongoing good-faith exchange of information, (d) and not reflective of a pattern or practice of non-compliance by the Plan.

h. **Authorized Representatives.** An authorized representative, such as a spouse or an adult child, may submit a Claim or appeal on behalf of a Participant if the Participant has previously designated the individual to act on his or her behalf. An Appointment of Authorized Representative form, which may be obtained from the Trust Fund office, must be used to designate an authorized representative. The Trust Fund office may request additional information to verify that the designated person is authorized to act on the Participant's behalf.

A health care professional with knowledge of the Participant's medical condition may act as an authorized representative in connection with an Urgent Claim without the Participant having to complete the Appointment of Authorized Representative form.

3. APPEAL PROCEDURES

a. **Appealing an Adverse Benefit Determination.** If a Claim is denied in whole or in part, or if the Participant disagrees with the decision made on a Claim, the Participant may appeal the decision. Appeals must be made in writing and must be submitted to the Trust Fund office within 180 days after the Participant receives the notice of Adverse Benefit Determination. However, in certain circumstances the time frame for submitting your appeal may be extended (or delayed) under contractual requirements that may exist between Anthem Blue Cross and a Preferred Provider, Medicare or other organization. Specifically, the time period in such cases may be extended where a contract provider, Medicare or other organization has an agreement that allows for a longer period to file an appeal with the Trust and the contract provider can demonstrate with satisfactory proof that the appeal submission date complies with the terms of its respective agreements and/or law.

(i) Urgent Claims. Appeals of Adverse Benefit Determinations regarding Urgent Claims must be made within 180 days after receipt of the Notice of Adverse Benefit Determination by either:

a. Calling the Trust Fund office and asking to speak to the Utilization Review Representative. All oral requests must be followed by a faxed written request within 24 hours.

b. Faxing the request to the attention of the Utilization Review Representative.

Appeals of Urgent Claims may not be submitted via the US Postal service.

(ii) Concurrent Claims. Appeals of Adverse Benefit 'Determinations regarding Concurrent Claims must be made in the same manner described for Urgent Claims.

(iii) Post-Service and Disability Claims. The appeal of a Post-Service or Disability Claim must be submitted in writing to the Trust Fund Office within 180 days after receipt of the Notice of Adverse Benefit Determination and must include:

a. the patient's name and address;

b. the Participant's name and address, if different;

c. a statement that this is an appeal of an Adverse Benefit Determination to the Board of Trustees;

d. the date of the Adverse Benefit Determination; and the basis of the appeal, i.e., the reason(s) why the Claim should not be denied.

b. The Appeal Process. The Participant will be given the opportunity to submit written comments, documents, and other information for consideration during the appeal, even if such information was not submitted or considered as part of the initial benefit determination. The Participant will be provided, upon request and free of charge, reasonable access to and copies of all Relevant Documents pertaining to his or her Claim.

A different person will review the appeal than the person who originally made the initial Adverse Benefit Determination on the Claim. The reviewer will not give deference to the initial Adverse Benefit Determination. The decision will be made on the basis of the record, including such additional documents and comments that may be submitted by the Participant.

If the Claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was Investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. Upon request, the Participant will be provided with the identification of medical or vocational experts, if any, that gave advice on the Claim, without regard to whether the advice was relied upon in deciding the Claim.

c. **Time Frames for Sending Notices of Appeal Determinations.**

(i) Urgent Claims. Notice of the appeal determination for Urgent Claims will be sent within 72 hours of receipt of the appeal by the Trust Fund Office.

(ii) Concurrent Claims. Notice of the appeal determination for a Concurrent Claim that involves an extension of an Urgent Care Claim will be sent by the Plan within 72 hours of receipt of an appeal by the Trust Fund Office.

(iii) Post-Service and Disability Claims. Ordinarily, decisions on appeals involving Post Service and Disability Claims will be made at the next regularly scheduled meeting of the Board of Trustees following receipt of Participant's request for review. However, if the request for review is received at the Trust Fund Office within 30 days before the next regularly scheduled meeting, the request for review may be considered at the second regularly scheduled meeting following receipt of the Participant's request. In special circumstances, a delay until the third regularly scheduled meeting following receipt of the Participant's request for review may be necessary. The Participant will be advised in writing in advance if this extension will be necessary. Once a decision on review of Participant's Claim has been reached, the Participant will be notified of the decision as soon as possible, but no later than 5 days after the decision has been reached.

If the decision on review is not furnished to the Participant within the time specified in this Subsection (C), Participant's Claim shall be deemed denied upon review. Participant shall be free to bring an action upon his Claim in accordance with Subsection e, below.

d. **Content of Appeal Determination Notices.** The determination of an appeal will be provided to the claimant in writing. The **notice of a denial of an appeal for non-disability claims** will include:

(i) the specific reason(s) for the determination;

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

(iii) a statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge;

(iv) a statement of the Participant's right to bring a civil action under ERISA Section 502(a) following an adverse benefit determination on appeal and any Plan imposed limitation to sue;

(v) if an internal rule, guideline or protocol was relied upon, a statement that a copy is available upon request at no charge; and

(vi) if the determination was based on Medical, Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge.

For **Appeals of Disability Claims**, the Appeal Denial Notice will contain:

(i) Reference to the specific Plan provision(s) on which the determination is based;

(ii) Explanation for: (a) disagreeing with the views of any health care professional who treated you or vocational professionals who evaluated the claim, when you present those views to the Plan (if applicable), (b) disagreeing with the view of medical or vocational experts whose advice was obtained on behalf of the Plan in connection with a claimant's denial, without regard to whether the advice was relied upon in making the benefit determination (if applicable), and (c) disagreeing with the view of any disability determination made by the Social Security Administration (if applicable);

(iii) Statement that either the specific internal rules, guidelines, protocols, standards or other similar criteria of the Plan relied upon in making the denial or alternatively, a statement that such rules, guidelines, protocols, standards or other similar criteria does not exist;

(iv) If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge;

(v) Statement that the Participant is entitled to receive reasonable access to and copies of all documents relevant to the Claim, upon request and free of charge; and

(vi) Any Plan imposed timeline for filing a lawsuit pursuant to your right under ERISA section 502(a) and the expiration date for bringing suit.

e. **When a Lawsuit may be Started.** No Employee, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. A Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision. In addition, any lawsuit for benefits, breach of fiduciary duty or for any other reason must be filed in federal district court in the Northern District of California. In addition, Participants beneficiaries and other persons or entities are not permitted to participate in Class Action lawsuits against the Plan or the Trustees.

No lawsuit may be started more than one year after the date on which an appeal has been denied or if there was no formal appeal one year from the date of the adverse determination.

4. STANDARD EXTERNAL REVIEW OF CLAIMS FOR BENEFITS.

a. **Request for External Review.** If you receive a notice of denial either at the claim level or any of the mandatory levels of appeal with respect to medical, dental or prescription drug benefits, you or your authorized representative have the option to file a written request for an external review with the Trust Fund Office, provided the request is filed within four months after the date of receipt of the denial notice. (Note: For prescription drugs, the claims administrator is Sav-Rx.) If there is no corresponding date four months after the date of receipt of such a notice, then the request must be filed by the first day of the fifth month following the receipt of the notice. For example, if the date of receipt of the notice is October 30, because there is no February 30, the request must be filed by March 1. If the last filing date falls on a Saturday, Sunday, or Federal holiday, the last filing date is extended to the next day that is not a Saturday, Sunday, or Federal holiday.

Effective June 1, 2022, External review is available only for those claims that involve:

a. Medical judgment (e.g., a claim that is denied on the basis of medical necessity or because a treatment is experimental or investigational), as determined by the external reviewer; or

b. Rescissions of coverage (whether or not the rescission has any effect on any particular benefit at that time); or

c. Plan's failure to adhere to its Internal Claims and Appeals Process without meeting an exception (“Deemed Exhaustion Rule”); or

d. Certain No Surprises Act Claims under CM Section 110 as discussed below.

External Review of Certain No Surprises Act Claims (CAA Section 110). This External Review process is intended to comply with the No Surprises Act external review requirements. The Plan will comply with an applicable external review process, as described in 26 CFR 54.9815-2719(d), 29 CFR 2590.715-2719(d), and 45 CFR 147.136(d) and any subsequent implementing regulations. As such, eligible participants and dependents have the right to request external review after he/she has exhausted the Plan's current internal claims and appeals rules, upon receipt of an adverse benefit determination as it relates to whether the Plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations for certain No Surprises Act claims and services mentioned in this section. This means that, generally, you may only seek external review after a final determination has been made on your appeal. External Review is available only with respect to the following types of claims (whether urgent, concurrent, pre-service or post-service claim is denied):

a. out-of-network emergency services,

b. non-emergency services provided by a non-network provider at an in-network facility and

c. out-of-network air ambulance services.

External review is permitted only in certain cases for adverse benefit determinations (including a final internal adverse benefit determination) by the Plan that involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, as well as a consideration of whether the Plan is complying with the surprise billing and cost sharing protections under ERISA sections 716 and 717 and§§ 2590.716-4 through 2590.716-5 and 2590.717-1.

To illustrate, the scope of claims eligible for external review include:

a. Whether a particular item or service constitutes treatment for emergency services.

b. Whether services provided by an out-of-network provider at an in-network facility is subject to the No Surprises Act.

c. Whether an individual was in a condition to receive Patient protection notice under the No Surprises Act and able to waive the right to those protections.

d. Whether a provider has coded the claim correctly, consistent with the treatment the patient actually received.

e. Whether cost-sharing was appropriately calculated for claims for ancillary services provided by an out-of-network provider at an in-network facility.

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

ARTICLE XIV: POTENTIAL LOSS AND/OR DELAYED PAYMENT OF BENEFITS

You or your beneficiary could lose your benefits or have payments delayed in at least the following circumstances:

A. **Exclusions/Co-Payments/Ineligible for Coverage.** The various plans and insurance policies contain exclusions that may preclude you from having coverage. You are also responsible for co-payments in most situations. And you must be eligible for coverage when claims are incurred.

B. **Fail to File Complete Application.** Benefits may not be payable until a completed application and other required forms and information is received by the Trust Fund Office.

C. **Incomplete Information/False Statements.** If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the plan or benefits provided may be postponed or cancelled.

If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information, and any attorney fees and costs incurred in effecting recovery or which were incurred as a result of the false statement or information. This includes but is not limited to costs incurred by the Trust Fund Office, reasonable attorney fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

D. **Employer's Failure to Timely Make Required Contributions.** If your contributing employer fails to make a required contribution on your behalf and you do not have any hours in your hour bank, you will lose eligibility under the Plan.

E. **Subrogation/Third Party Claims.** The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible. The Plan may recover any amount it pays for claims from which a Covered Individual received payment under a court judgment, settlement agreement, insurance payment or any other form of payments from a third party, including any payment received from an insurance company.

F. **Coordination of Benefits with Other Plans.** If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims. The Plan sets for the order and procedures for determining which Plan pays first.

G. **Work-Related Injuries.** The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This is so even though you have not filed a claim with workers compensation.

H. **Failure to Enroll in Medicare Parts A and B.** If you are eligible for and fail to enroll in Medicare parts A and B the Plan will not pay many of your claims.

I. **Right to Recover Claims Paid or Offset of Future Claims.** The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

J. **Prohibited Employment in the Electrical Industry.** If you work in the Electrical Industry for an Employer that does not contribute to the Plan, you will no longer have coverage under the Plan. You will lose eligibility. Moreover, loss of coverage for this reason is not a qualifying event under COBRA.

K. **Inadequate or Improper Evidence.** The Plan grants the Board of Trustees the power to deny, suspend or discontinue benefits to a Participant who fails to submit at the request of the Trust Fund Office any information or proof or coverage reasonably required to administer the Plan.

L. **Plan Termination.** If the Plan terminates, benefits may no longer be provided.

ARTICLE XV: MISCELLANEOUS BENEFIT PROVISIONS

A. CLAIM FORMS - MUST USE PLAN FORMS WHEN REQUIRED

All claims for benefits shall be filed on forms provided by the Plan, which will be available from the Trust Fund Office. The Plan, upon receipt of a written notice of claim, will furnish such forms to the claimants.

B. PROOF OF LOSS - 180 DAYS TO SUBMIT A CLAIM FOR REIMBURSEMENT

Written proof of loss must be furnished to the Plan for any claim for any benefits payable under the Plan, other than Death or Prescription Drug Benefit within 180 days after the beginning date of such loss. A proof of loss shall be considered to have been furnished as soon as a claim is received at the Trust Fund Office, provided the claim is substantially complete, with all necessary documentation required by the form. If the form is not substantially complete, or if required documentation has not been furnished, the claimant will be notified as soon as possible of what is necessary to complete the claim. Failure to furnish such proof within the time required shall not invalidate nor reduce any claim if the Trustees determine it was not reasonably possible to give proof within such time, provided, except in the absence of the claimant's legal capacity, it is later than one year from the time proof is otherwise required.

C. PAYMENT OF CLAIMS-PAYMENTS MADE TO HOSPITALS AND PROVIDERS

Subject to any written direction of the Participant in an application or otherwise, all or a portion of any benefits provided by the Plan on account of hospital, medical or surgical services may, at the Plan's option, and unless the claimant requests otherwise in writing, no later than the time for filing proof of such loss, be paid directly to the Hospital or individual rendering such services.

Amounts payable for other than Death Benefits will be paid to the claimant subject to the provisions set forth in this section, or if the claimant is deceased, to the claimant's beneficiary.

D. PLAN MAY REQUIRED A PHYSICAL EXAMINATION

The Plan, at its own expense, has the right and opportunity to have a physician or provider of its choice examine the person of any individual whose injury or sickness is the basis of a claim, when and as often as it may reasonably require during the continuance of a claim under the Plan.

E. CONSTRUCTION

The validity of the Plan or any of its provisions will be determined under and will be construed according to ERISA and other federal law and, to the extent permissible, according to the laws of the State of California. This Plan is intended to be construed as a whole, but in the event any provision of this Plan is held illegal or invalid for any reason, such determination will not affect the remaining provisions of this Plan and the Plan will be construed and enforced as if said illegal or invalid provision had never been included.

F. NO VESTED RIGHT TO BENEFITS OR COVERAGE

Nothing in this Plan shall be construed as giving Employees, retired or terminated, dependents or any other person a vested right to continued coverage under this Plan. The Trustees retain full authority to amend or terminate the benefits, coverage and required payments at any time.

G. FACILITY OF PAYMENT - PAYMENTS TO GUARDIANS OR OTHERS

Any death benefit payable to a minor may be paid to the legally appointed guardian of the minor or, if there is no such guardian, to such adult or adults as have complied with the requirements of California or other applicable law for receipt of such benefit on behalf of the minor, after which the Plan shall have no further obligations with respect to such minor.

H. AVAILABLE ASSETS FOR BENEFITS-LIMIT ON PAYMENT OF BENEFITS

Benefits provided by this Plan 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 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 required in the 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 this Plan shall be construed as obligating any contributing Employer or any U.A. Local to make benefit payments or contributions 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 contributing Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

I. INCOMPETENCE OR INCAPACITY - AUTHORITY TO MAKE PAYMENTS

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

J. GENDER AND NUMBER

Wherever applicable, the masculine pronoun as used herein shall include the feminine and the singular the plural.

ARTICLE XVI: AMENDMENT/TERMINATION/MERGER OF PLAN

A. AMENDMENT OF PLAN

The Board of Trustees has the discretion to amend the Plan at any time. Moreover, if the Collective Bargaining Agreement is amended by the insertion or deletion of provisions relating to the Plan, the Board of Trustees will amend the Plan to effectuate the intent of the amendment to the Collective Bargaining Agreement, unless such amendment conflicts with applicable law or is actuarially unsound.

Any amendment may apply to all groups and/or Participants covered by the Plan or only to certain groups of Participants. Retroactive amendments may be made to the extent permissible under ERISA. Except as is permitted or required by applicable law, no amendment may divest any accrued benefits which have previously been vested.

B. TERMINATION OF PLAN

It is anticipated that the Plan is permanent and will continually be in operation. It is, however, legally necessary to consider the possibility of termination of the Plan and to state the rights of the Participants in such an unlikely event.

The parties to the Collective Bargaining Agreements between IBEW Local 234 and the various Employer associations may terminate the Plan in whole or in part. Although there is no intent to terminate the Plan, there is no guarantee that the Plan will last forever.

C. MERGER OR CONSOLIDATION

In the event of a merger or consolidation of the Plan with, or transfer in whole or in part, of the assets or liabilities of the Plan to any other Pension Plan, each Participant is entitled to a benefit immediately after the merger, consolidation or transfer which is at least equal to the benefit such Participant would be entitled to receive before such merger, consolidation or transfer.

ARTICLE XVII: ADDITIONAL INFORMATION REQUIRED BY ERISA

A. NAME AND TYPE OF PLAN

The name of the Plan is the IBEW Local 234 Health & Welfare Plan ("Plan"). The Plan is tax-exempt under Section 501(c)(9) of the Internal Revenue Code.

B. PLAN ADMINISTRATOR

The Board of Trustees is the designated Plan Administrator of the Plan under ERISA. The Board is responsible for the operation and administration of the Plan, including ensuring that information regarding the Plan is reported to governmental agencies and disclosed to Plan Participants and beneficiaries in accordance with ERISA. The Board has contracted with BeneSys, Inc. to be the Fund Manager for the Plan. You may contact the Plan as follows:

Fund Manager/IBEW Local 234 Health & Welfare Plan
1731 Technology Drive, Suite 570, San Jose, CA 95110
(408) 588-3753

This is the address for the Plan Administrator.

C. AGENT FOR THE SERVICE OF LEGAL PROCESS

The person designated as agent for service of legal process is:

Richard K. Grosboll
Neyhart, Anderson, Flynn & Grosboll
369 Pine Street, Suite 800
San Francisco, CA 94104-3323
(415) 677-9440

Service of legal process may also be made upon the Fund Manager, any Plan Trustee, or the Board of Trustees, at the addresses listed on page i of this booklet.

D. PLAN YEAR

The Plan Year commences on June 1 and ends of May 31.

E. EMPLOYER IDENTIFICATION

The Internal Revenue Service Employer Identification Number (EIN) for this Plan is 94-62-50011. The Plan Number is 501.

F. FUNDING CONTRIBUTIONS AND COLLECTIVE BARGAINING AGREEMENTS

The Plan is maintained in accordance with Collective Bargaining Agreements between the IBEW Local 234 and certain designated Employer associations (and some individual Employers), which require Employers to contribute to the Plan. The Plan Office will provide you upon written request with information on whether a particular Employer for whom you work is contributing to the Plan and if the Employer is a contributor, the Employer's address.

G. FUND MEDIUM

Assets of the Plan are held in Trust.

ARTICLE XVIII: CONSOLIDATED APPROPRIATIONS ACT OF 2021 ("CAA")

Effective July 1, 2022, the Plan rules have been amended to comply with certain provisions of Division BB of the Consolidated Appropriations Act under the No Surprises Act (Title I) and Transparency (Title II) provisions, including any subsequent implementing regulations as it relates to the CAA.

1. **Identification Cards (CAA Section 107).** The Plan's Identification Cards (physical or electronic) issued to participants or eligible dependents will include:

a. the amount of the in-network and out-of-network (if any) deductible and out-of-pocket maximums,

b. telephone number and website address to seek further consumer assistance.

2. **Ensuring Continuity of Care (CAA Section 113).** When a medical/mental health/substance abuse provider or contracted facility is removed from the Plan coverage, following termination of the provider/facility contract between the Plan and/or Provider/Facility, the Plan (through Anthem Blue Cross) will timely notify participants or their eligible dependents who are receiving continuing care for a serious and complex condition (serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time) from that provider or facility that: (a) the Provider/Facility is no longer part of the Plan's network and (2) the Participant or eligible Dependent has the right to continue receiving transitional care for up to ninety (90) days at the in-network cost sharing and at the same terms that would have applied had termination not occurred.

3. **Accuracy of Provider Directory Information (CAA Section 116).**

a. ***Verification Process.*** Not less frequently than once every ninety (90) days the Plan, through Anthem Blue Cross, will verify and update its provider directory information included on the Plan's database. Providers are required to submit regular updates to the plan to assist with the verification and update process, including notice of material changes to their provider directory information. The database of provider directories must then be updated within two (2) business days of the plan receiving such data from the providers.

b. ***Response Protocol.*** The Plan will respond to a participant or dependent's request (whether by telephone, electronic, web-based or internet-based), within one (1) business day of the request, about a provider's network status. The Plan must also retain communication records for two (2) years.

c. ***Database.*** The Plan will maintain a public website directory that contains a list of each of its contracted and facility providers, relevant information (name, address, specialty, number, digital contact information) and post information on balance billing protections and appropriate federal and state agency contacts to report violations.

d. ***Cost-Sharing/or Services provided Based on Reliance on Incorrect Provider Network Information.*** If participant or dependent provides documentation (ex. received through database, provider directory or response protocol) that he/she received and relied on incorrect information from the Plan about a provider's network status prior to the visit and the item or services would otherwise be covered under the plan if furnished by a participating provider/facility, the Plan cannot impose cost-sharing amount greater than in-network rates and it must count towards the participant or dependent's in-network out-of-pocket maximum and in-network deductible. If a provider submits a bill to an enrollee in excess of the in-network cost-sharing amount and the enrollee pays, the provider must refund that excess amount with interest.

4. <u>Surprise Billing Protections (CAA Sections 102 and 105)</u>.

a. ***Balance Billing Prohibition.*** Participants and dependents are prohibited from being balance billed for (1) **out-of-network emergency services,** (2) **non-emergency services performed by an out-of-network provider received at in-network facility,** and (3) **out-of-network air ambulance services.** Providers are prohibited from holding patients liable for excess amounts not covered by the Plan.

b. ***Cost-Sharing Limits.*** In addition, for the three above-mentioned surprise items and services (#1, #2 and #3) any cost-sharing (such as copayment, coinsurance or deductible) must not be greater than the in-network cost sharing amount and must count towards the Plan's in-network deductible and out-of-pocket maximums, as of the items and services were provided by a participating provider. The participant or dependent's cost-sharing is based on the recognized amount. By statute, the recognized amount is (in order of priority) for only out-of-network emergency services and non-emergency services provided by an out-of-network provider at participating facilities:

(1) Amount determined by All-Payer Model Agreement, if applicable;

(2) Amount under specified state law (as applied to plans regulated by state law);

(3) The lesser of the billed charge or **Qualifying payment amount** (is the median of the contracted rates for similar services in a particular geographic area-based on the metropolitan statistical area adjusted by the consumer price index for inflation for items or services furnished during 2023 or subsequent years).

For out-of-network air ambulance bills the cost-sharing limit must be calculated by using the lesser of the: (1) billed charge or (2) qualifying payment amount.

c. ***Determination of Out-of-Network Rates.*** By statute, the total amount to be paid to a provider/facility must be based on (less any cost-sharing from participant or dependent) the following out-of-network rate, in order of priority:

(1) Amount determined by All-Payer Model agreement, if applicable (does not apply to this Plan),

(2) Amount under specified state law (as applied to plans regulated by state law and does not apply to this Plan);

(3) Amount agreed upon by Plan and Provider/Facility; and

(4) Amount determined by Independent Dispute Resolution Entity.

5. Patient Protections Disclosure Requirements Against Balance Billing.

The Plan is required to make publicly available, by posting on the website of the Plan and including on each Explanation of Benefits for an item or service as it relates to:

(1) emergency services or

(2) non-emergency services provided by non-participating provider at in-network facility, balance billing and patient protections in certain circumstances and appropriate government agency contact information if the participant or dependent believes the provider/facility has violated the No Surprises Act provisions.

6. Out-of-Network Rate Independent Dispute Resolution Process for Certain No Surprises Act Items and Services (CAA Section 103).

A federal Independent Dispute Resolution ("IDR") process (also known as an arbitration procedure) is required for disputes involving out-of-network rates between the Plan and Out-of-Network provider/facility ("disputing parties") as it relates only to: (1) out-of-network emergency services, (2) non-emergency services provided by a non-network provider at an in-network facility and (3) out-of-network air ambulance services. Not all items and services are eligible for the federal IDR process. But, before initiating the IDR process, the disputing parties must first initiate a 30-day open negotiation period (meaning must engage in open negotiations within 30 days of receiving initial payment or denial) to settle an out-of-network payment rate for covered items and services under the No Surprises Act. However, the Trust Fund reserves the right at any time in its sole discretion to settle a claim by agreement with a Non-Contract Provider, provided that, if the settled Claim is covered by the No Surprises Act the settlement does not result in higher participant or dependent cost-sharing as permitted under the No Surprises Act. If any federal court case including, government guidance, regulations, and/or subsequent law invalidates any portion of the IDR process, as it relates to the No Surprises Act, then the invalidated portions will also not apply to this Plan.

In case of a failed open negotiation period, either party may initiate the federal IDR process as follows:

Independent Dispute Resolution	Timeline
Initiate **30 business day** open negotiation period	**30 business days** starts on date of initial payment or notice of denial of payment
Initiate IDR process following failed open negotiation	**4 business days** starts the business day after open negotiation period ends
Mutual Agreement on certified IDR entity selection	**3 business days** after the IDR initiation date
Departments select certified IDR entity in the case of no conflict-free selection by the parties	**6 business days** after the IDR initiation date
Submit payment offers and additional information to certified IDR entity	**10 business days** after date of certified IDR entity selection
Payment determinations made (*certified IDR issue binding determination selecting one of the parties' offers as the payment amount*)	**30 business days** after the date of certified IDR entity selection
Payment submitted to the applicable party	**30 business days** after the payment determination

Both parties are responsible for an administrative fee and the non-prevailing party is responsible for the certified IDR entity fee for the use of this process. The 2022 administrative fee and allowable IDR entity fee ranges is available at: Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act (cms.gov).

Batched Items and Services. Batching means multiple items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the federal IDR process. Batching is also allowed for claims submitted within a 30-day period that meet the following criteria:

- Services furnished by the same provider or facility
- Services provided to participants and dependents under the same plan
- Services for treatment of similar conditions.

The party that initiated the IDR process cannot initiate a new IDR process with the same party and for same services for 90 days. However, on the 90 day period is up, the party may submit (appropriately batched) claims from that 90-day period to IDR.

Factors Considered by IDR Entity.
When making a payment determination, the certified IDR entities must begin with the presumption that the Qualifying Payment Amount is the appropriate out-of-network amount. If a party submits additional information that is allowed under the statute, then the certified IDR entity must consider the information if it is credible. For the IDR entity to deviate from the offer closest to the Qualifying Payment Amount, any information submitted must clearly demonstrate that the value of the item or services is materially different from the QPA.

Within 30 days, the IDR entity selects one of the offers submitted and must consider:

- Offers by both parties; and
- Qualifying payment amount for the same service in the same geographic region.

The IDR entity can also consider the following factors:

- Training, experience, quality, and outcomes measurements;
- Market shares of parties;
- Acuity of patients/complexity of cases;
- Teaching status, case mix, scope of services of facility; and
- Good faith efforts by parties to contract and contracting rate history from last four years.

The IDR entity cannot consider:

- Usual and customary rates;
- Billed charges; and
- Payment rates by public payors, including Medicare, Medicaid, CHIP, and Tricare

STATEMENT OF ERISA RIGHTS

As a Participant in the IBEW Local 234 Health and Welfare ("Plan"), you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that Participants are entitled to:

RIGHT TO RECEIVE INFORMATION ABOUT THE PLAN AND YOUR BENEFITS

- Examine without charge at the Plan Office and at other specified locations such as worksites and the Union office, documents governing the Plan, including Collective Bargaining Agreements and the latest annual report (Form 5500 series) filed with the Department of Labor (and which is available at the Public Disclosure room of the Department of Labor's Employee Benefits Security Administration ("EBSA") office.

- Obtain copies of Plan documents governing the Plan (those documents which are required by law to be furnished) upon written request to the Plan. Pursuant to ERISA, the Plan Office may require that you pay a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report, known as a Summary Annual Report ("SAR"). The Plan is required by law to furnish each Participant with the SAR.

- Receive a statement informing you whether you have a right to receive a pension at Normal Retirement Age and if so, what your benefits would be at Normal Retirement Age if you stop working under the Plan now. This statement must be requested in writing and is not required to be given more than once every 12 months. The Plan must provide the statement free of charge.

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people responsible for operating the Plan. The people who operate your Plan, called "fiduciaries," 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 or entity, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a pension benefit or exercising your rights under ERISA.

ENFORCING YOUR RIGHTS UNDER ERISA

If your claim for a benefit is denied in whole or in part, you will 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 federal court. In such a case, the court may require the Plan Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Administrator.

If you have a claim for benefits which is denied or ignored in whole or in part, and which is upheld on appeal (or ignored), you may file a lawsuit. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a domestic relations order, you may file suit in federal court.

If it should happen that Plan fiduciaries misuse the Plan's money or other assets, 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.

If you file a lawsuit, the court will decide who should pay court costs and legal fees. If you are successful, the court may order the person(s) you have sued to pay your costs and fees. If you lose, the court may order you to pay the Trust's or other defendants' costs and fees (e.g., your claim was frivolous). **Under the Plan, you are required to file a lawsuit within one year after your appeal has been denied**.

If you have any questions about your Plan, you should contact the Trust Fund Office.

If you have any questions about this statement or about your rights under ERISA, of if you need assistance in obtaining documents form the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration (EBSA), U.S. Department of Labor, listed in your telephone directory or:

Office of Participant Assistance
U.S. Department of Labor
Employee Benefits Security Administration
200 Constitution Avenue NW
Washington, D.C. 20210

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at 1 (866) 444-3272 or contact the EBSA field office nearest you.

You may find answers to your questions and a list of EBSA offices at:

https://www.dol.gov/agencies/ebsa/about-ebsa/about-usl.

PRIVACY NOTICE

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 and contact the Plan Office if you have any questions.

The IBEW Local 1234 Health and Welfare Plan ("Plan") is required by state and federal law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that medical information, known as Protected Health Information ("PHI") that identifies you is kept private and secure to the extent required by law. We are also required to give you this Notice regarding the uses and disclosures of medical information that may be made by the Plan, and your rights and the Plan's legal duties with respect to such information. The Plan must also follow the duties and privacy practices described in this Notice. This Notice and its contents are intended to conform to the requirements of HIPAA, and it applies to all records containing your PHI that are created, transmitted or retained by the Plan or Business Associates (including their subcontractors) that help administer the Plan.

- **PHI Defined.** The term "PHI" or "medical information" in this Notice means individually identifiable medical and genetic information that relates to your physical or mental health condition, the provision of health care to you, or payment of such health care.

- **De-Identified PHI.** This Notice does not apply to information that has been de-identified. De-identified information neither identifies nor provides a reasonable basis to identify you.

- **Minimum Necessary.** When using or disclosing PHI, 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 factors and limitations and any applicable law requiring greater disclosure.

The Plan Office will also let you know promptly if a breach occurs that may have compromised the privacy or security of your information. The Plan will not use or share your information other than as permitted by HIPAA and unless you tell the Plan Office it can in writing. If you tell the Plan office it can, you may change your mind at any time, but let the Plan Office know in writing.

The rights in this Notice apply to you, your Spouse, and your Dependents.

Please be advised that other vendors or entities (ex. Anthem Blue Cross, VSP, Delta Dental, Sav-RX) that provide medical, dental and vision services to you related your participation in the Plan have issued or may issue you a separate Notice regarding disclose of PHI that is maintained by those entities.

For more information please see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

Our Uses and Disclosures

How do we typically use or share your medical information?

The following categories describe different ways that we use and disclose medical information. For each category of uses and disclosures, the Plan will explain what it means and present some examples. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information may fall within one of the categories.

Treatment	The Plan can use your PHI to tell you about or recommend possible treatment options or alternatives that may be of interest to you, including but not limited to consultations and referrals between your providers. *Example: Doctor sends us information about your diagnosis and treatment plan so we can arrange additional services.*
For Payment	We may use and disclose medical information about you to determine eligibility for Plan benefits, to facilitate payment for the treatment and services you receive from health care providers, to determine benefit responsibility under the Plan, or to coordinate Plan coverage. *Example: We share your eligibility for benefits information with Anthem Blue Cross to confirm whether payment will be made for a particular service.*
For Health Care Operations/Appeals	The Plan can use and disclose health information about you for Plan operations that are necessary to run the Plan. The Plan may also release your PHI to the Board of Trustees or an Appeals Committee if it is needed to make a decision regarding an appeal. *Example: We use health information in reviewing & responding to appeals, medical reviews, legal services, audit services, Plan administrative activities, premium rating, or conducting quality assessment and improvement activities.*
As Required By Law	The Plan can use and disclose your health information if required by state, federal or local laws. *Example: We share information with the Department of Health & Human Services for compliance with federal privacy laws.*
To Avert a Serious Threat to Health or Safety/Assist Public Health Issues	The Plan can use and disclose your health information when it believes, in good faith, that such disclosure is necessary to prevent a serious threat to the safety and health of you, another individual, or the public. This includes disclosing medical information for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury, or disability. *Example: We share health information to report suspected abuse, neglect or domestic violence if we have a reasonable belief, or to prevent disease, or to help with product recalls, or to prevent/reduce a serious threat to anyone's health or safety.*
To Inform You About Treatment Alternatives or Other Health Related Benefits	The Plan may use PHI to identify whether you may benefit from communications from the Plan regarding (1) available provider networks or available products or services under the Plan, (2) your treatment, (3) case management or care coordination for you, or (4) recommended alternative treatments, therapies, health care providers, or settings of care for you. *Example: We may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.*

Disclosure to Health Plan Sponsor & IBEW Local Unions	Medical information may be disclosed to the Plan Sponsors, i.e., IBEW 6, 100, 180, 234, 302, 332, 340, 551, 591, 595, 617 or 684, and the Associations, or Plan Trustees, solely for purposes of administering benefits under the Plan.
Organ and Tissue Donation	The Plan can share health information about you with organizations involved in procuring, banking or transplanting organs and tissues, as necessary.
Military, Veterans, and Inmates	The Plan may release health information about you as required by military command authorities, if you are a member of the armed forces, or to a correctional institute or law enforcement official, if you are an inmate or under custody of a law enforcement official.
Respond to Lawsuits and Disputes	The Plan can use and disclose your health information to respond to a court order, administrative proceeding, arbitration, subpoena, other lawful process or similar proceeding. *Example: We receive a discovery request in which you are a party involved in a lawsuit.*
Government or Law Enforcement Requests	To the extent permitted or required by local/state/federal law, the Plan may release your health information to law enforcement official or for law enforcement purposes, to authorized government agencies, to health oversight agencies, or to comply with laws related to workers' compensation claims. *Example: We release health information because there is suspicion that your death was the result of a criminal conduct, or because of civil administrative or criminal investigations, audits, inspections, licensure or disciplinary action, or other activities necessary for the government to monitor government programs (such as Medicare fraud review), or for special government functions such as military, national security and presidential protective services.*
Research	The Plan can use and share your health information for health research subject to certain conditions.
Child Immunization Proof to Schools	The Plan may disclose proof of immunization of a student to the School, prior to admitting the student, where State or other law requires such information, upon obtaining the consent of the parent, guardian, or student of consenting age. Consent may be given by e-mail, in writing, over the phone, or in person.
Decedent's Health Information	The Plan may disclose your PHI to your family members and others who were involved in your care or payment of your care, unless doing so is inconsistent with your prior written expressed wishes that was given to the Plan. However, PHI of persons who are deceased for more than 50 years is not protected under the HIPAA privacy and security rules. *Example: We disclose health information to a coroner or medical examiner necessary to identify a deceased person or determine the cause of death.*
Business Associates & Subcontractors	The Plan may also share your PHI with business associates, including its subcontractors or agents that perform certain administrative services for the Plan. As required by federal law, the Plan has a written contract with each of its business associates that contains provisions requiring them to protect the confidentiality of your PHI and to not use or disclose your PHI other than as permitted by the contract or as permitted by law.

Our Uses and Disclosure

For certain information, you can tell us your choices about what we share

Except as provided for in this Notice or as permitted by law, the Plan will not release your PHI without your written authorization. If you have a clear preference for how the Plan shares your information in the situations described below, contact the Plan office and tell the Plan what you want the Plan to do. The Plan Office has an Authorization Form that you may sign to authorize release of all or part of your PHI.

In these cases below, you have both the right and choice to tell the Plan to:

- Share information with your family, close friends, or others involved in your health care or payment for your case, as long as you do not object.

- Share information in a disaster relief situation.

If you are not able to tell the Plan your preference, for instance if you are unconscious or not around, the Plan may share your health information if the Plan believes it is in your best interest. The Plan may also share your health information when needed to lessen a serious and imminent threat to health or safety.

In these cases, the Plan will not share your information unless you give your written authorization subject to your right to revoke, amend, or limit your authorization in writing, at any time:

- **Psychotherapy Notes.** Psychotherapy notes are separately filed notes about your conversations with your mental health professional. Although this Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you.

- **Marketing Authorization.** The Plan cannot receive financial remuneration (direct or indirect payment) from third parties in exchange for the marketing of PHI unless permitted under HIPAA or with your prior written authorization. Marketing is any communication about a product or service that encourages recipients of the communication to purchase or use the product or service. This Plan never markets personal information.

- **Sale of PHI.** The Plan is prohibited from directly or indirectly receiving financial or non-financial remuneration in cash or in kind (including granting license rights) from a third party in exchange for your PHI unless permitted under HIPAA or with your prior written authorization. This Plan does not sell your PHI.

- **Fundraising Purposes.** Except as permitted under HIPAA or with your prior written authorization, the Plan cannot use or disclose your PHI for fundraising purposes. Although the Plan does not use nor does it intend to use your PHI for fundraising purposes, it must inform you of your right to opt out of receiving any fundraising communications (whether received in writing or over the phone) if it uses or discloses your PHI for fundraising purposes.

- **Genetic Information.** Your PHI includes genetic information. Regarding underwriting, which is premium rating, or similar activities, the Plan will not use or disclose genetic information about an individual, as prohibited under the Genetic Information Nondiscrimination Act of 2008. Also, the Plan cannot use your genetic information to decide whether it will give you coverage and the price of that coverage.

- **Other Uses of Medical Information.** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

Your Rights

When it comes to your health information, you have certain rights.

This section explains your rights and some of your responsibilities to help you.

- **Right to Inspect and Copy Your Medical Information.** You have the right to inspect and copy medical information that may be used to make decisions about your Plan benefits. To inspect and copy such medical information, you must submit your request in writing to the Plan Office. This includes the right to request a copy of your PHI in hard copy or electronic form contained in a designated record set for so long as the Plan maintains the PHI. The electronic form you request may be in the form of MS Word, Excel, text, or text-based PDF, among other formats. If the format you request is not readily producible, the Plan will provide you with a copy of your PHI in a readable format as agreed to by you and the Plan. Your requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. If you request a copy of this information, we may charge a fee for the costs of copying, mailing or other supplies associated with your request. We may deny your request to inspect and copy your medical information in certain very limited circumstances. If you are denied access to medical information, you may request that the denial be reviewed. Pursuant to government regulations, you do not have a right to copies of psychotherapy notes.

- **Right to Amend/Correct Your Medical Information.** If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend or correct the information. You have the right to request an amendment or correction for as long as the information is kept by or for the Plan. To request an amendment, your request must be made in writing and submitted to the Plan Office. In addition, you must provide a reason that supports your request. The Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide you with a written denial that explains the basis for the denial. You or your personal representative may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your health information.

  We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that (1) is not part of the medical information kept by or for the Plan, (2) was not created by us, unless the person or entity -that created the information is no longer available to make the amendment, (3) is not part of the information which you would be permitted to inspect and copy, or (4) or is accurate and complete.

- **Right to an Accounting of Disclosures.** You have a right to obtain an accounting of certain disclosures of your medical information. This right to an accounting extends to disclosures <u>other than</u> disclosures made to carry out treatment, payment or health care operations, to individuals about their own medical information, incident to an otherwise permitted use or disclosure, pursuant to an authorization, for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, as part of a limited data set, and for other national security or to correctional institutions or law enforcement officials.

To request an accounting of disclosures, you must submit your request in writing to the Plan Office. The requested information will be provided within 30 days if the information is maintained on site or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if the plan is unable to comply with deadline. Your request must specify a time period, which may not be longer than six years. Your request should indicate in what form you want the accounting (for example, paper or electronic). The first accounting you request within a 12-month period will be free. For additional accountings, we may charge you for the costs of providing the accounting. We will notify you of the cost involved and you may choose to withdraw or modify your request at that time before any costs are incurred.

- **Right to Request Restrictions.** You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment or health care operations. We are not, however, required to agree to your request. To request restrictions, you must make your request in writing to the Plan Office. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit our use, disclosure or both; and (3) to whom you want the limits to apply.

- **Right to Request Confidential Communications.** You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by mail. Such requests shall be honored if, in the sole discretion of the Plan, the requests are reasonable and can be accommodated with minimal disruption to Plan administration. However, the Plan must say "yes" if you tell us you would be in danger if the Plan office does not honor your request. To request confidential communications, you must make your request in writing to the Plan Office. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice.** You have the right to a paper copy of this notice. You may ask us to give you a copy of this notice at any time. Even if you have agreed to receive this notice electronically, you are still entitled to a paper copy of this notice.

- **Right to Provide an Authorization.** As noted above, the Plan may request your written authorization for uses and disclosures that are not identified by this Notice or permitted by law. Any authorization you provide regarding the use and disclosure of your PHI may be revoked at any time in writing.

- **Right to a File a Complaint.** If you believe your privacy rights have been violated, you may file a complaint with the Plan Office by contacting the Privacy Officer listed on the last page or with the U.S. Department of Health and Human Services, Office for Civil Rights by sending a letter to 200 Independence Avenue S.W., Washington, D.C. 20201, calling (877) 696-6775, or **visiting www.hhs.gov/ocr/privacy/hipaa/complaints/**. You must file a complaint within 180 days after the occurrence of the event or violation. You may also contact the Privacy Officer if you have any questions or concerns regarding your Privacy rights or regarding the specifics of filing a complaint. All complaints must be submitted in writing. You will not be penalized for filing a complaint and the Plan will not retaliate against you for filing a complaint.

- **Right to Notice in Event of Breach of Unauthorized Disclosure (Breach Notice).** You have the right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI. There will be a presumption that any unauthorized acquisition, access, use, or disclosure of your PHI, in violation of the Privacy rule is a breach, *unless* the Plan demonstrates that there is a low probability that your PHI has been compromised based on the results of a risk assessment or an exception permitted by the Privacy Rule applies. This Plan has implemented a policy to require the performance of a risk assessment in all cases of impermissible uses or disclosures of PHI to ensure your PHI will not be compromised and intends on complying with any future guidance on risk assessments.

- **Right to Restrict Disclosure of PHI If Paying Out-of-Pocket.** If you paid for services out-of-pocket, in full, for a specific item or service, you have the right to ask your Health Care Provider to not disclose your PHI related to that item or service to the Plan for purposes of payment of health care operations. The Health Care Provider must accommodate your request, except where the Health Care Provider is required by law to make a disclosure**.**

- **Right to Choose Someone to Act For You (Personal Representative).** You may exercise your rights through a Personal Representative, who will be required to produce evidence of his/her authority to act on your behalf before he/she will be given access to your health information or be allowed to take any action for you. The Plan Office will verify that the person has this authority and can act for you before it takes any action. Proof of such authority may take one of the following forms: (a) notarized power of attorney for health care purposes or (b) court order of appointment of the individual as your conservator or guardian.

Changes to This Notice

The effective date of this Notice is **February 1, 2022.** We can change this Notice, and the changes will apply to all information we have about you. Any changes that may occur, we will mail the revised Notice to participants. The New Notice will be available upon request (at any time), on our website, and we will mail a copy to you. The Plan will comply with the terms of any such Notice currently in effect.

Requests for Information

Questions regarding this information should be addressed to the HIPAA Privacy Officer at:

IBEW LOCAL 234 HEALTH AND WELFARE PLAN
1731 Technology Drive, Suite 570
San Jose, CA 95110
Telephone: (408) 588-3753 or Toll Free 1-800-885-3753
Website: www.IBEW234benefits.org