IBEW LOCAL 595 TRUST FUNDS

NEW MEMBER ENROLLMENT PACKAGE CONTENTS

This enrollment package was sent to you because you are, or will be eligible for health care coverage. In order to better understand the benefits that are available to you, it is important that you carefully read all of the information included. It is equally important that you fully and legibly complete and return all required documents as soon as possible. Any missing information or incomplete forms, will delay the processing of your medical and/or dental claims. For your convenience, forms to be returned to the Trust Fund Office are listed blow each item. It may not be necessary to complete all forms listed depending on your coverage choices. Please contact the Fund Office if you have any questions regarding your enrollment!

Medical Comparison/Summaries of Benefit Coverage:	Enclosed are the Comparison of Benefits Summary and the Summaries of Benefit Coverage for Medical benefits that are available to you. This includes Blue Cross Indemnity Plan, Additional Deductible Blue Cross Indemnity Plan without vision or dental coverage, Kaiser HMO Plan & United Healthcare Plan. Please review your Summary Plan Description to find the benefit coverage available to you and any exclusion that may apply.
Dental Comparison:	Included is a Comparison of Benefits Summary of Dental benefits available to you. These include Delta Dental Plan and United HealthCare Dental. Please review your summary Plan Description to find the benefit coverage available to you and any exclusion that may apply.
Vision Plan:	Enclosed is an outline of the Vision Benefits are provided through Vision Service Plan (VSP). Please review your Summary Plan Description to find information about the covered benefits that are available to you.
Member Assistance Program:	Enclosed is an informational brochure regarding the MAP benefits provided through Optum Behavioral Health. Please review your Summary Plan Description to find information about the covered benefits that are available to you.

7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566 • P O Box 3420 • San Ramon, CA 94583
Phone 925-208-9996 • Toll Free 888-512-5863 • Fax 925-362-8564
www.ibew595benefits.org • staff@ibew595benefits.org

Dependent Coverage Letter:

The enclosed letter provides an explanation and check list of the items needed to add dependents to your health plan. If you are married, have a domestic partner, children or other dependents, please provide the following:

□ **Marriage Certificate**

□ **Declaration of Domestic Partnership**

□ **Birth Certificates**

□ **Proof of Dependency for Adopted Children**

Health & Welfare Beneficiary Form:

It is strongly recommended that you complete the H&W Beneficiary Form for the Death and Accidental Death & Dismemberment benefits to ensure that benefits are paid according to your wishes.

□ **Health & Welfare Beneficiary Form**

HRA Deduction Authorization Form:

This form when completed provides authorization to have the monthly Buy Up amount, currently $279.50, to be deducted from your Health Reimbursement Account (HRA). The buy up is required for coverage in the UnitedHealthcare HMO or the Blue Cross PPO (Self-Funded Indemnity Plan).

Authorization for Release of Protected Health Information:

It is strongly recommended that you, your spouse and your eligible Dependents over age 18 complete the Authorization for Release of Protected Health Information Form.

Notice of the Privacy Practices (HIPAA) and Authorization Form:

Please read the enclosed HIPAA Privacy notice, which explains your rights, and how and when medical information may be disclosed. Effective April 2003, you will no longer receive health care information over the phone for any member of your family other than yourself or your minor child (under age 18), unless a signed authorization form is on file at this office. Please complete and sign the enclosed Authorization for Release of Protected Health Information form and return it to the Fund Office.

Monthly Status Reports:

These will be mailed to you around the second week of each month. This Report gives you important information about your eligibility for Health Care Coverage, and also provides you with a

record of hours and contributions as reported by your employer. **It is important that your carefully review this report each month.**

Notice of COBRA Continuation Coverage Rights:

Please read this information. This notice contains important information about your rights to COBRA continuation coverage, which is a temporary extension of coverage under the Plan.

Enrollment Form:

The Enrollment Form must be completed on **both sides** and returned to the address listed below as soon as possible. This will prevent any delay in processing claims because of missing information. **Please note the Trustees have adopted the Kaiser HMO as the base medical plan. Any medical plan options that are more expensive than the Kaiser HMO will require employees to "buy up" to other plan options.** Currently the "buy up" cost to select the Blue Cross Indemnity or United Healthcare HMO medical plan option is $279.50.

□ **Enrollment Form: Is required for all Participants**

□ **Kaiser Enrollment Form: Only complete if selecting Kaiser**

□ **UHC Enrollment Form: Only Complete if selecting United Healthcare HMO**

Failure to complete & return the enrollment form or failure to pay any required Buy Up will result in being defaulted into the Additional Deductible Medical Option without Vision or Dental.

I.D. Cards will be ordered as soon as we receive the completed Enrollment Form Application, Beneficiary Card, and the completed Other Insurance Inquiry form.

Summary Plan Description's:

These booklets contain the rules of the Plan and a description of the Benefit's available to you and your dependents.

IBEW LOCAL 595 HEALTH & WELFARE PLAN
ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
COMPARISON OF BENEFITS SUMMARY Effective 2/1/2015

COVERAGE FEATURES	Self Funded INDEMNITY PLAN Coverage Worldwide *	Self Funded ADDITIONAL DEDUCTILE INDEMNITY PLAN Without Vision or Dental Coverage Worldwide	KAISER PERMANENTE HMO	UNITED HEALTHCARE HMO *
CHOICE OF PROVIDERS	Choose an Anthem Blue Cross physician and save money. Choose an Anthem Blue Cross hospital to receive maximum benefits. $250 charge will apply for not using an Anthem Blue Cross hospital when available.	Choose an Anthem Blue Cross physician and save money. Choose an Anthem Blue Cross hospital to receive maximum benefits. $250 charge will apply for not using an Anthem Blue Cross hospital when available.	Must use Kaiser Permanente Facilities and Providers.	Must use United Healthcare/PacifiCare HMO providers.
PLAN MAXIMUMS	**No annual or lifetime plan maximums for Covered Charges that are considered "essential health benefits" under Patient Protection Affordable Care Act.**	**No annual or lifetime plan maximums for Covered Charges that are considered "essential health benefits" under Patient Protection Affordable Care Act.**	No plan maximum.	No plan maximum.
OUT-OF-POCKET MAXIMUMS	For in-network Anthem Blue Cross providers: All benefits paid at 80% after satisfying deductible of $200 per person, maximum $400 per family. For non-network: All benefits paid at 60% of reasonable and customary charges after satisfying deductible of $200 per person, maximum $400 per family. All covered benefits paid at 100% after $10,000 of covered expenses after deductible.	For in-network Anthem Blue Cross providers: All benefits paid at 80% after satisfying deductible of $3554per person, maximum $3754 per family. For non-network: All benefits paid at 60% of reasonable and customary charges after satisfying deductible of $3554 per person, maximum $3774 per family. All covered benefits paid at 100% after $10,000 of covered expenses after deductible.	$1,500 Individual $3,000 Family	$2,000 Individual $6,000 Family
HOSPITAL CONFINEMENT Room and Board, surgery, anesthesia and miscellaneous	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible. There is a $250 charge will apply for not using an Anthem Blue Cross hospital when available.	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible. There is a $250 charge will apply for not using an Anthem Blue Cross hospital when available.	No charge.	No charge.
DOCTOR VISITS Office Hospital	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible.	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible.	$10 per visit No charge.	$20 per visit
OUTPATIENT LAB & X-RAYS	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible.	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible.	No charge.	No charge.

IBEW LOCAL 595 HEALTH & WELFARE PLAN
ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
COMPARISON OF BENEFITS SUMMARY Effective 2/1/2015

*Requires the monthly payment of $279.50 Buy-up.

COVERAGE FEATURES	Self Funded INDEMNITY PLAN Coverage Worldwide *	Self Funded ADDITIONAL DEDUCTILE INDEMNITY PLAN Without Vision or Dental Coverage Worldwide	KAISER PERMANENTE HMO	UNITED HEALTHCARE HMO *
PRESCRIPTION DRUGS	**Benefits through OptumRx:** (30-day supply) $5 co-pay – Generic $20 co-pay – Preferred Brand $35 co-pay Non-Preferred Brand $4000 (Individual)/$8000 (Family) Maximum Out-of-Pocket/calendar year Mail Order available (90-day Supply)	**Benefits through OptumRx;** (30-day supply) $5 co-pay – Generic $20 co-pay – Preferred Brand $35 co-pay Non-Preferred Brand $1046 (Individual)/$3754 (Family) Maximum Out-of-Pocket/calendar year Mail Order available (90-day Supply)	**Benefits through Kaiser:** $10 per prescription / refill at Kaiser Permanente Pharmacies (up to a 100 day supply) – Generic $25 per prescription / refill at Kaiser Permanente Pharmacies (up to a 100 day supply) - Brand	**Benefits through OptumRx (formerly Prescription Solutions):** (30-day supply) $10 co-pay – Generic/Brand $20 co-pay – Non-Formulary Mail Order available (90-day Supply)
MATERNITY CARE Mother's Hospital Expenses Mother's Office Expenses **Newborn Care:** must be enrolled within 31 days from date of birth.	(Members and Spouses only) Paid as any other hospital confinement For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	(Members and Spouses only) Paid as any other hospital confinement For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	No Charge. *$5 per visit pre-natal care* No charge in hospital if enrolled within 31 days of birth	No Charge. No charge in hospital if enrolled within 31 days of birth
PHYSICAL THERAPY	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	$10 per visit (short term)	$20 per visit (short term)
CHIROPRACTIC & ACUPUNCTURE	Covered as any other medical expense (based on allowable charges and Plan guidelines).	Covered as any other medical expense (based on allowable charges and Plan guidelines).	Chiropractic - $10 per visit; 30 visits per calendar year. Acupuncture – Not covered	Not covered
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	Durable medical equipment - rental or purchase as allowed by Plan. For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	Durable medical equipment - rental or purchase as allowed by Plan. For in-network Anthem Blue Cross PPO providers: Pays 80% after deductible. For non-network: Pays 60% after deductible	No charge when medically necessary and prescribed by Plan physician and in accordance with DME formulary guidelines.	No charge with authorization. $5,000 annual maximum per calendar year.
AMBULANCE SERVICES	Pays 80% after deductible if required to move patient from place of injury or illness to nearest hospital equipped to provide necessary care.	Pays 80% after deductible if required to move patient from place of injury or illness to nearest hospital equipped to provide necessary care.	No charge if authorized and medically necessary.	No charge if authorized and medically necessary.

*Requires the monthly payment of $279.50 Buy-up.

IBEW LOCAL 595 HEALTH & WELFARE PLAN
ACTIVE EMPLOYEES and NON-MEDICARE RETIREES
COMPARISON OF BENEFITS SUMMARY Effective 2/1/2015

COVERAGE FEATURES	Self Funded INDEMNITY PLAN Coverage Worldwide *	Self Funded ADDITIONAL DEDUCTILE INDEMNITY PLAN Without Vision or Dental Coverage Worldwide	KAISER PERMANENTE HMO	UNITED HEALTHCARE HMO *
EMERGENCY CARE AND OUT OF AREA SERVICE *(Outside of Plan facilities)*	Coverage applies worldwide.	Coverage applies worldwide.	$75 co-pay *(waived if admitted).* Worldwide coverage for Urgent & Emergency services. Follow-up and routine care not covered.	$50 copay, waived if admitted. Routine care not covered.
SPECIAL NOTES	Non-network Indemnity payments are based on allowable charges (reasonable and customary). Blood donations for your own surgery covered if physician recommends.	Non-network Indemnity payments are based on allowable charges (reasonable and customary). Blood donations for your own surgery covered if physician recommends.	*Allergy testing $10 per visit.* *Allergy injection $3 per visit.*	Infertility Not Covered
MENTAL HEALTH* Outpatient Inpatient *Unlimited for AB88 conditions	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**	**Outpatient: $10 per individual visit $5 per group visit** **Inpatient – No Charge**	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**
CHEMICAL DEPENDENCY ***(Alcohol or Drug Abuse)***	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**	**Inpatient detoxification – no charge** **Outpatient: $10 per individual visit $5 per group visit.**	**Covered as any other medical expense (based on allowable charges and Plan guidelines).**
MEMBER ASSISTANCE PROGRAM	Benefits are provided by Optum Health. Please see separate booklet for services provided			
DENTAL COVERAGE	Benefits provided by Delta Dental or UHC Dental. Please see separate booklets for services provided.	**No dental benefits available under this option.**	Benefits provided by Delta Dental or UHC Dental. Please see separate booklets for services provided.	Benefits provided by Delta Dental or UHC Dental. Please see separate booklets for services provided.
VISION COVERAGE	Benefits are provided by Vision Service Plan (VSP). Please see separate booklet for services provided.	**No vision benefits available under this option.**	Benefits are provided by Vision Service Plan (VSP). Please see separate booklet for services provided.	Benefits are provided by Vision Service Plan (VSP). Please see separate booklet for services provided.

*Requires the monthly payment of $279.50 Buy-up.

"Year" means calendar year unless otherwise indicated.

NOTE: This “COMPARISON OF BENEFITS SUMMARY” is intended only as a general description of the principle features of the benefit plans. Each Plan's benefit booklet should be consulted for additional information.

IBEW LOCAL 595 HEALTH & WELFARE PLAN
MEDICARE RETIREES
2015 COMPARISON OF BENEFITS SUMMARY

COVERAGE FEATURES **All Retirees are required to have both Medicare Part A & Part B.**	**(Not Applicable for Local 639 Members)** **KAISER PERMANENTE SENIOR ADVANTAGE** (Medicare HMO Plan)	**UNITED HEALTHCARE MEDICARE NATIONAL PPO** **(**Medicare PPO Plan**)**
CHOICE OF PROVIDERS	Must use Kaiser facilities and providers	Must use UHC Medicare National PPO provider
PLAN MAXIMUMS	No plan maximums.	No plan maximums.
OUT OF POCKET MAXIMUMS	$1,500 for individual $3,000 for family	Not applicable.
HOSPITAL CONFINEMENT *Room and board, surgery, anesthesia and miscellaneous*	No charge	No charge.
DOCTOR VISITS Office Hospital	 $10 per visit No charge	 $5 per visit No charge
OUTPATIENT LAB & X-RAYS	No charge	No charge
AMBULANCE SERVICES	No charge if authorized and medically necessary.	No charge if authorized.
MATERNITY CARE Mother's Hospital Expenses Mother's Expenses - Office **Newborn Care:** must be enrolled within 31 days from date of birth	 No charge *$5 per visit pre-natal* No charge in hospital if enrolled within 31 days of birth.	 No charge. No charge. No charge in hospital if enrolled within 31 days of birth.
EYE EXAMINATIONS **VISION COVERAGE**	$10 per visit ***$150 optical allowance****** every 24 months *your price will be reduced by the allowance indicated. If the price of the item (s) you select exceed the allowance, you will pay the difference.	$5 per visit Up to $130 eyewear allowance every 24-months, or up to $175 contact lens allowance in lieu of eyewear every 24 months.

Rev date: 01/07/2015

IBEW LOCAL 595 HEALTH & WELFARE PLAN
MEDICARE RETIREES
2015 COMPARISON OF BENEFITS SUMMARY

COVERAGE FEATURES	(Not Applicable for Local 639 Members) KAISER PERMANENTE SENIOR ADVANTAGE (Medicare HMO Plan)	UNITED HEALTHCARE MEDICARE NATIONAL PPO (Medicare PPO Plan)
PHYSICAL THERAPY	$10 per visit (short term)	No Charge (short term)
PRESCRIPTION DRUGS	**Benefits provided through Kaiser:** $10 per prescription or refill at a Kaiser Permanente Pharmacies (100 day supply).	**Benefits through Secure Horizons** (30-day supply) $10 co-pay – Generic/Brand $20 co-pay – Non-Formulary Mail Order Pharmacy $20 co-pay generic (90 day supply) $40 co-pay brand (90 day supply)
CHIROPRACTIC & ACUPUNCTURE	Chiropractic - $10 per visit; 30 visits per calendar year. Acupuncture - not covered	Chiropractic -$5 co-pay/ 12 visits per year Acupuncture - not covered
PROSTHETIC DEVICES AND DURABLE MEDICAL EQUIPMENT	No charge when medically necessary and prescribed by Plan physician and in accordance with DME formulary guidelines.	No charge with authorization.
EMERGENCY CARE AND OUT OF SERVICE AREA (*Outside of Plan facilities*)	$35 co-pay ***(waived if admitted).*** Worldwide coverage for urgent & emergency services. Routine care not covered.	$50 co-pay, waived if admitted. Routine care not covered.
DENTAL COVERAGE	Covered by Delta or UHC Dental	Covered by Delta or UHC Dental
SPECIAL NOTES Your eligible dependents are: Lawful Spouse Registered Domestic partner & children. Unmarried children age 26.	Allergy testing and treatment, $3 per visit. <u>Home Health</u>: Skilled nursing visits on intermittent basis - no charge when prescribed. <u>Facility:</u> Skilled Nursing/100 days per year no charge if authorized.	Allergy testing and treatment no charge. $5 co-pay <u>Facility:</u> Skilled nursing 100 days per benefit period no charge if authorized.

NOTE: This COMPARISON OF BENEFITS SUMMARY is intended only as a general description of the principle features of the benefit plans.
Each Plan's benefit booklet should be consulted for additional information.

Rev date: 01/07/2015

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.kp.org** or by calling **1-800-278-3296**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See chart on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes. $1,500** Individual/**$3,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, health care this plan doesn't cover, and cost sharing for certain services listed in plan documents.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes.** For a list of **plan providers**, see **www.kp.org** or call **1-800-278-3296**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**Yes**, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 per visit	Not Covered	——————none——————
	Specialist visit	$10 per visit	Not Covered	Services related to infertility covered at $10 per visit.
	Other practitioner office visit	$10 per visit for chiropractic services, $10 per visit for acupuncture services.	Not Covered	Up to 30 visits per calendar year for chiropractic services, Physician referred acupuncture.
	Preventive care/ screening/ immunization	No Charge	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No Charge; Lab tests: No Charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary .	Generic drugs	$10 per prescription for 1 to 100 days	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	$25 per prescription for 1 to 100 days	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 per procedure	Not Covered	————————none————————
	Physician/surgeon fees	No Charge	Not Covered	————————none————————
If you need immediate medical attention	Emergency room services	$75 per visit	$75 per visit	————————none————————
	Emergency medical transportation	No Charge	No Charge	————————none————————
	Urgent care	$10 per visit	$10 per visit	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	————————none————————
	Physician/surgeon fee	No Charge	Not Covered	————————none————————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 per individual visit; $5 per group visit	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	No Charge	Not Covered	——————none——————
	Substance use disorder outpatient services	$10 per individual visit; $5 per group visit	Not Covered	——————none——————
	Substance use disorder inpatient services	No Charge	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge; Postnatal care: No Charge	Prenatal care: Not covered; Postnatal care: Not covered	Prenatal: Cost sharing is for routine preventive care only; Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per calendar year.
	Rehabilitation services	Inpatient: No Charge; Outpatient: $10 per visit	Not Covered	——————none——————
	Habilitation services	$10 per visit	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	Up to 100 days maximum per benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	————————none————————
	Glasses	Not Covered	Not Covered	————————none————————
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover **(This isn't a complete list. Check your policy or plan document for other excluded services.)**

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care unless medically necessary
- Weight loss programs

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Acupuncture (plan provider referred)
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-278-3296. You may also contact your state insurance department; the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Kaiser Permanente at 1-800-278-3296 or online at www.kp.org/memberservices.

If this coverage is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/heatlhreform, and the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

If this coverage is not subject to ERISA, you may also contact the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

Additionally, this consumer assistance program can help you file your appeal:

Department of Managed Health Care Help Center	1-888-466-2219
980 9th Street, Suite 500	www.healthhelp.ca.gov
Sacramento, CA 95814	helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 or TTY/TDD 1-800-777-1370

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 or TTY/TDD 1-800-777-1370

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-757-7585 or TTY/TDD 1-800-777-1370

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 or TTY/TDD 1-800-777-1370

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,320
- **Patient pays** $220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,720
- **Patient pays** $680

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$0
Copays	$600
Coinsurance	$0
Limits or exclusions	$80
Total	**$680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.kp.org** or by calling **1-800-278-3296**.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$0**	See chart on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes. $1,500** Individual/**$3,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, health care this plan doesn't cover, and cost sharing for certain services listed in plan documents.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**No.**	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	**Yes.** For a list of **plan providers**, see **www.kp.org** or call **1-800-278-3296**.	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	**Yes**, but you may self-refer to certain specialists.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	**Yes.**	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Copayments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Coinsurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **coinsurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use **plan providers** by charging you lower **deductibles**, **copayments** and **coinsurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$10 per visit	Not Covered	——————none——————
	Specialist visit	$10 per visit	Not Covered	Services related to infertility covered at $10 per visit.
	Other practitioner office visit	$10 per visit for chiropractic services, $10 per visit for acupuncture services.	Not Covered	Up to 30 visits per calendar year for chiropractic services, Physician referred acupuncture.
	Preventive care/ screening/ immunization	No Charge	Not Covered	Some preventive screenings (such as lab and imaging) may be at a different cost share.
If you have a test	Diagnostic test (x-ray, blood work)	X-ray: No Charge; Lab tests: No Charge	Not Covered	——————none——————
	Imaging (CT/PET scans, MRI's)	No Charge	Not Covered	——————none——————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.kp.org/formulary .	Generic drugs	$10 per prescription for 1 to 100 days	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Preferred brand drugs	$25 per prescription for 1 to 100 days	Not Covered	In accordance with formulary guidelines. Certain drugs may be covered at a different cost share.
	Non-preferred brand drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
	Specialty drugs	Same as preferred brand drugs.	Not Covered	Same as preferred brand drugs when approved through exception process.
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	$10 per procedure	Not Covered	————————none————————
	Physician/surgeon fees	No Charge	Not Covered	————————none————————
If you need immediate medical attention	Emergency room services	$75 per visit	$75 per visit	————————none————————
	Emergency medical transportation	No Charge	No Charge	————————none————————
	Urgent care	$10 per visit	$10 per visit	Non-Plan providers covered when outside the service area.
If you have a hospital stay	Facility fee (e.g., hospital room)	No Charge	Not Covered	————————none————————
	Physician/surgeon fee	No Charge	Not Covered	————————none————————

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	$10 per individual visit; $5 per group visit	Not Covered	——————none——————
	Mental/Behavioral health inpatient services	No Charge	Not Covered	——————none——————
	Substance use disorder outpatient services	$10 per individual visit; $5 per group visit	Not Covered	——————none——————
	Substance use disorder inpatient services	No Charge	Not Covered	——————none——————
If you are pregnant	Prenatal and postnatal care	Prenatal care: No Charge; Postnatal care: No Charge	Prenatal care: Not covered; Postnatal care: Not covered	Prenatal: Cost sharing is for routine preventive care only; Postnatal: Cost sharing is for the first postnatal visit only.
	Delivery and all inpatient services	No Charge	Not Covered	——————none——————
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Up to 2 hours maximum per visit, up to 3 visits maximum per day, up to 100 visits maximum per calendar year.
	Rehabilitation services	Inpatient: No Charge; Outpatient: $10 per visit	Not Covered	——————none——————
	Habilitation services	$10 per visit	Not Covered	——————none——————
	Skilled nursing care	No Charge	Not Covered	Up to 100 days maximum per benefit period.
	Durable medical equipment	No Charge	Not Covered	Must be in accordance with formulary guidelines. Requires prior authorization.
	Hospice service	No Charge	Not Covered	Limited to diagnoses of a terminal illness with a life expectancy of twelve months or less.

Common Medical Event	Services You May Need	Your cost if you use a Plan Provider	Your cost if you use a Non-Plan Provider	Limitations & Exceptions
If your child needs dental or eye care	Eye exam	No Charge	Not Covered	——————none——————
	Glasses	Not Covered	Not Covered	——————none——————
	Dental check-up	Not Covered	Not Covered	You may have other dental coverage not described here.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Dental care (Adult)
- Hearing aids
- Long-term care
- Non-emergency care when traveling outside the U.S.
- Private-duty nursing
- Routine foot care unless medically necessary
- Weight loss programs

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Acupuncture (plan provider referred)
- Bariatric surgery
- Chiropractic care
- Infertility treatment
- Routine eye care (Adult)

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the **premium** you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply. For more information on your rights to continue coverage, contact the plan at 1-800-278-3296. You may also contact your state insurance department; the U.S. Department of Labor, Employee Benefits Security Administration, at 1-866-444-3272 or www.dol.gov/ebsa; or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact: Kaiser Permanente at 1-800-278-3296 or online at www.kp.org/memberservices.

If this coverage is subject to ERISA, you may contact the Department of Labor's Employee Benefits Security Administration at 1-866-444-EBSA (3272) or www.dol.gov/ebsa/heatlhreform, and the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

If this coverage is not subject to ERISA, you may also contact the California Department of Insurance at 1-800-927-HELP (4357) or www.insurance.ca.gov.

Additionally, this consumer assistance program can help you file your appeal:

Department of Managed Health Care Help Center	1-888-466-2219
980 9th Street, Suite 500	www.healthhelp.ca.gov
Sacramento, CA 95814	helpline@dmhc.ca.gov

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-788-0616 or TTY/TDD 1-800-777-1370

TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-278-3296 or TTY/TDD 1-800-777-1370

CHINESE (中文): 如果需要中文的帮助，请拨打这个号码 1-800-757-7585 or TTY/TDD 1-800-777-1370

NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-278-3296 or TTY/TDD 1-800-777-1370

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $7,320
- **Patient pays** $220

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient Pays:

Deductibles	$0
Copays	$20
Coinsurance	$0
Limits or exclusions	$200
Total	**$220**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,720
- **Patient pays** $680

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient Pays:

Deductibles	$0
Copays	$600
Coinsurance	$0
Limits or exclusions	$80
Total	**$680**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **copayments**, and **coinsurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✗ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✗ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **copayments**, **deductibles**, and **coinsurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

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Benefit Summary

Group 750 IBEW 595 HEALTH TRUST (Early RETIREES)

Principal Benefits for Kaiser Permanente Traditional Plan (2/1/15—1/31/16)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area (your Home Region), except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*) for authorized referrals, hospice care, Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

Health Plan believes this coverage is a "grandfathered health plan" under the Patient Protection and Affordable Care Act. If you have questions about grandfathered health plans, please call our Member Service Contact Center.

Accumulation Period

The Accumulation Period for this plan is 1/1/15 through 12/31/15 (calendar year).

Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share during the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:

For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year

Plan Deductible	None
Lifetime Maximum	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits for evaluations and treatment	$10 per visit
Most Specialty Care Visits for consultations, evaluations, and treatment	$10 per visit
Routine physical maintenance exams, including well-woman exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling and consultations	No charge
Scheduled prenatal care exams	No charge
Routine eye exams with a Plan Optometrist for Members under age 19	No charge
Routine eye exams with a Plan Optometrist for Members age 19 and older	No charge
Hearing exams	No charge
Urgent care consultations, evaluations, and treatment	$10 per visit
Most physical, occupational, and speech therapy	$10 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Covered individual health education counseling	No charge
Covered health education programs	No charge

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	**You Pay**
Emergency Department visits	$75 per visit

Note: This Cost Share does not apply if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Cost Share).

Ambulance Services	**You Pay**
Ambulance Services	No charge

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines at a Plan Pharmacy or through our mail-order service:	
Most generic items	$10 for up to a 100-day supply
Most brand-name items	$25 for up to a 100-day supply

Benefit Summary *(continued)*

Durable Medical Equipment (DME)	You Pay
DME items that are essential health benefits in accord with our DME formulary guidelines	No charge
DME items that are not essential health benefits in accord with our DME formulary guidelines	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$10 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge
Other	**You Pay**
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Ostomy and urological supplies	No charge
Prosthetic and orthotic devices that are essential health benefits	No charge
Prosthetic and orthotic devices that are not essential health benefits	No charge
Hospice care	No charge
Chiropractic	$10 per visit, 30 visits per year

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

Group 750 IBEW 595 HEALTH TRUST Medicare RETIREES (KPSA)

Principal Benefits for Kaiser Permanente Senior Advantage (HMO) with Part D (2/1/15—1/31/16)

The Services described below are covered only if all of the following conditions are satisfied:

- The Services are Medically Necessary and in accord with Medicare guidelines
- The Services are provided, prescribed, authorized, or directed by a Plan Physician and you receive the Services from Plan Providers inside our Northern California Region Service Area, except where specifically noted to the contrary in the *Evidence of Coverage* (*EOC*)

Accumulation Period	
The Accumulation Period for this plan is 1/1/15 through 12/31/15 (calendar year).	
Out-of-Pocket Maximum	
For Services subject to the maximum, you will not pay any more Cost Share during the calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Plan Deductible	None
Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits for evaluations and treatment	$10 per visit
Most Specialty Care Visits for consultations, evaluations, and treatment	$10 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$10 per visit
Hearing exams	$10 per visit
Urgent care consultations, evaluations, and treatment	$10 per visit
Physical, occupational, and speech therapy	$10 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays, annual mammograms, and laboratory tests	No charge
Manual manipulation of the spine	$10 per visit
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	$35 per visit
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines	$10 for up to a 100-day supply
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric care	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$10 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge

(continues)

Benefit Summary *(continued)*

Other	You Pay
Eyewear purchased at Plan Medical Offices or Plan Optical Sales Offices every 24 months	Amount in excess of $150 Allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices	No charge
Ostomy and urological supplies	No charge
Chiropractic	$10 per visit, 30 visits per year

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, please refer to the *EOC*. Please note that we provide all benefits required by law (for example, diabetes testing supplies).

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling (888) 512-5863 or (925) 208-9996.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$200** person / **$400** family	You must pay all the covered costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes.** There are no additional out-of-pocket expenses after $10,000 in covered medical expenses are incurred each policy year (see exceptions pages 2 – 5). For prescription drugs, after out-of-pocket expenses of $4000 (Individual)/$8000 (Family) have been incurred.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, deductibles, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**There is no annual maximum.**	
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.anthem.com or call 1-800-333-0912	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Anthem Blue Cross in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Non-Network Provider	All Non-Network charges are subject to Reasonable & Customary Charge limitations
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance after deductible	40% co-insurance after deductible	
	Specialist visit	20% co-insurance after deductible	40% co-insurance after deductible	
	Other practitioner office visit	20% co-insurance after deductible	40% co-insurance after deductible	
	Preventive care/screening/immunization	No co-insurance	40% co-insurance after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Non-Network Provider	All Non-Network charges are subject to Reasonable & Customary Charge limitations
If you need drugs to treat your illness or condition More information about **prescription drug coverage** is available at www.optumrx.com.	Generic drugs	$5 co-pay(retail) $10 co-pay (mail order)	$5 co-pay(retail)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription – in-network only)
	Preferred brand drugs	$20 co-pay(retail) $40 co-pay (mail order)	$20 co-pay(retail)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription – in-network only)
	Non-preferred brand /Specialty drugs	$35 co-pay(retail) $70 co-pay (mail order)	$35 co-pay(retail)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription – in-network only)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need immediate medical attention	Emergency room services	20% co-insurance after deductible	40% co-insurance after deductible	
	Emergency medical transportation	20% co-insurance after deductible	40% co-insurance after deductible	
	Urgent care	20% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions All Non-Network charges are subject to Reasonable & Customary Charge limitations
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	A $250 charge will apply if you fail to choose a participating PPO in-patient Hospital facility when available. An additional $250 penalty will apply if pre-certification is not obtained for either PPO or non-PPO.
	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	There is also $250 penalty if pre-certification is not obtained for either PPO or non-PPO.
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	There is also $250 penalty if pre-certification is not obtained for either PPO or non-PPO.
If you are pregnant	Prenatal and postnatal care	20% co-insurance after deductible	40% co-insurance after deductible	
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions All Non-Network charges are subject to Reasonable & Customary Charge limitations
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Skilled nursing care	20% co-insurance after deductible	40% co-insurance after deductible	
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	
	Hospice service	20% co-insurance after deductible	40% co-insurance after deductible	
If your child needs dental or eye care	Eye exam	$20 Co-pay	$20 Co-pay	Contact VSP 1-800-877-7195 or VSP.com
	Glasses	$20 Co-pay	$20 Co-pay	
	Dental check-up	No co-insurance	No co-insurance after a $50 deductible	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Infertility treatment
- Private-duty nursing
- Weight loss programs
- Long-term care

Other Covered Services **(This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)**

- Bariatric surgery (if pre-approved by medical review)
- Emergency care when traveling outside the U.S.
- Dental care (Adult)
- Routine eye care (Adult)

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1(888)512-5863. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/dol/topic/health-plans/

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the administration offices of BeneSys Administrators at 7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566, (925) 208-9996. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-512-5863.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $5,770
- **Patient pays** $1,770

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$200
Co-pays	$10
Co-insurance	$1,410
Limits or exclusions	$150
Total	**$1,770**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $4,480
- **Patient pays** $920

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$200
Co-pays	$200
Co-insurance	$440
Limits or exclusions	$80
Total	**$920**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document by calling (888) 512-5863 or (925) 208-9996.

Important Questions	Answers	Why this Matters:
What is the overall deductible?	**$3554** person / **$3754** family	You must pay all the covered costs up to the **deductible** amount before this plan begins to pay for covered services you use. Check your policy or plan document to see when the **deductible** starts over. See the chart starting on page 2 for how much you pay for covered services after you meet the **deductible**.
Are there other deductibles for specific services?	**No.**	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out–of–pocket limit on my expenses?	**Yes.** There are no additional out-of-pocket expenses after $10,000 in covered medical expenses are incurred each policy year (see exceptions pages 2 – 5). For prescription drugs, after out-of-pocket expenses of $1046 (Individual)/$3754 (Family) have been incurred.	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out–of–pocket limit?	Premiums, deductibles, balance-billed charges, and health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	**There are no annual maximum.**	
Does this plan use a network of providers?	Yes. For a list of participating providers, see www.anthem.com or call 1-800-333-0912	If you use an in-network doctor or other health care **provider**, this plan will pay some or all of the costs of covered services. Be aware, your in-network doctor or hospital may use an out-of-network **provider** for some services. Plans use the term in-network, **preferred**, or participating for **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	No. You don't need a referral to see a specialist.	You can see the **specialist** you choose without permission from this plan.
Are there services this plan doesn't cover?	Yes.	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if

Questions: Call (925) 208-9996 for more information, including a copy of your Summary Plan Description that more fully describes benefits.

the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.

- The amount the plan pays for covered services is based on the **allowed amount**. If an out-of-network **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if an out-of-network hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan may encourage you to use Anthem Blue Cross in-network **providers** by charging you lower **deductibles**, **co-payments** and **co-insurance** amounts.

Common Medical Event	Services You May Need	Your cost if you use an		Limitations & Exceptions
		In-network Provider	Non-Network Provider	All Non-Network charges are subject to Reasonable & Customary Charge limitations
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	20% co-insurance after deductible	40% co-insurance after deductible	
	Specialist visit	20% co-insurance after deductible	40% co-insurance after deductible	
	Other practitioner office visit	20% co-insurance after deductible	40% co-insurance after deductible	
	Preventive care/screening/immunization	No co-insurance	40% co-insurance after deductible	
If you have a test	Diagnostic test (x-ray, blood work)	20% co-insurance after deductible	40% co-insurance after deductible	
	Imaging (CT/PET scans, MRIs)	20% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions: All Non-Network charges are subject to Reasonable & Customary Charge limitations
If you need drugs to treat your illness or condition More information about prescription drug coverage is available at www.optumrx.com.	Generic drugs	$5 co-pay(retail) $10 co-pay (mail order)	$5 co-pay(retail)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription – in-network only)
	Preferred brand drugs	$20 co-pay(retail) $40 co-pay (mail order)	$20 co-pay(retail)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription – in-network only)
	Non-preferred brand /Specialty drugs	$35 co-pay(retail) $70 co-pay (mail order)	$35 co-pay(retail)	Covers up to a 30-day supply (retail prescription); 90 day supply (mail order prescription – in-network only)
If you have outpatient surgery	Facility fee (e.g., ambulatory surgery center)	20% co-insurance after deductible	40% co-insurance after deductible	
	Physician/surgeon fees	20% co-insurance after deductible	40% co-insurance after deductible	
If you need immediate medical attention	Emergency room services	20% co-insurance after deductible	40% co-insurance after deductible	
	Emergency medical transportation	20% co-insurance after deductible	40% co-insurance after deductible	
	Urgent care	20% co-insurance after deductible	40% co-insurance after deductible	

OMB Control Numbers 1545-2229, 1210-0147, and 0938-1146

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions All Non-Network charges are subject to Reasonable & Customary Charge limitations
If you have a hospital stay	Facility fee (e.g., hospital room)	20% co-insurance after deductible	40% co-insurance after deductible	A $250 charge will apply if you fail to choose a participating PPO in-patient Hospital facility when available. An additional $250 penalty will apply if pre-certification is not obtained for either PPO or non-PPO.
	Physician/surgeon fee	20% co-insurance after deductible	40% co-insurance after deductible	
If you have mental health, behavioral health, or substance abuse needs	Mental/Behavioral health outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
	Mental/Behavioral health inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	There is also $250 penalty if pre-certification is not obtained for either PPO or non-PPO.
	Substance use disorder outpatient services	20% co-insurance after deductible	40% co-insurance after deductible	
	Substance use disorder inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	There is also $250 penalty if pre-certification is not obtained for either PPO or non-PPO.
If you are pregnant	Prenatal and postnatal care	20% co-insurance after deductible	40% co-insurance after deductible	
	Delivery and all inpatient services	20% co-insurance after deductible	40% co-insurance after deductible	

Common Medical Event	Services You May Need	Your cost if you use an In-network Provider	Your cost if you use an Non-Network Provider	Limitations & Exceptions: All Non-Network charges are subject to Reasonable & Customary Charge limitations
If you need help recovering or have other special health needs	Home health care	20% co-insurance after deductible	40% co-insurance after deductible	
	Rehabilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Habilitation services	20% co-insurance after deductible	40% co-insurance after deductible	
	Skilled nursing care	20% co-insurance after deductible	40% co-insurance after deductible	
	Durable medical equipment	20% co-insurance after deductible	40% co-insurance after deductible	
	Hospice service	20% co-insurance after deductible	40% co-insurance after deductible	
If your child needs dental or eye care	Eye exam	Not Covered	Not Covered	
	Glasses	Not Covered	Not Covered	
	Dental check-up	Not Covered	Not Covered	

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)

- Cosmetic surgery
- Weight loss programs
- Vision Care Services
- Infertility treatment
- Long-term care
- Private-duty nursing
- Dental Services

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)

- Bariatric surgery (if pre-approved by medical review)
- Emergency care when traveling outside the U.S.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy [does/ does not] provide minimum essential coverage.**

Does this Coverage Meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage [does/does not] meet the minimum value standard for the benefits it provides.**

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1(888)512-5863. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/dol/topic/health-plans/

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact the administration offices of BeneSys Administrators at 7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566, (925) 208-9996. You may also contact the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform.

Language Access Services:

[Spanish (Español): Para obtener asistencia en Español, llame al 1-888-512-5863.

To see examples of how this plan might cover costs for a sample medical situation, see the next page.

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care will also be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- **Amount owed to providers:** $7,540
- **Plan pays** $3090.80
- **Patient pays** $4,449.20

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$3574
Co-pays	$10
Co-insurance	$715.20
Limits or exclusions	$150
Total	**$4,449.20**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- **Amount owed to providers:** $5,400
- **Plan pays** $2,800
- **Patient pays** $2600

Sample care costs:

Prescriptions	$2,900
Medical Equipment and Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$2320
Co-pays	$200
Co-insurance	$0
Limits or exclusions	$80
Total	**$2600**

Questions and answers about the Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied by the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-network **providers**. If the patient had received care from out-of-network **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✘ **No.** Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✘ **No.** Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes.** When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes.** An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

This is only a summary. If you want more detail about your coverage and costs, you can get the complete terms in the policy or plan document at **www.welcometouhc.com/uhcwest** or by calling **1-800-624-8822.**

Important Questions	Answers	Why This Matters:
What is the overall deductible?	Participating: **$0** Individual / **$0** Family	See the chart starting on page 2 for your costs for services this plan covers.
Are there other deductibles for specific services?	No	You don't have to meet **deductibles** for specific services, but see the chart starting on page 2 for other costs for services this plan covers.
Is there an out-of-pocket limit on my expenses?	Yes, Participating: **$2,000** Individual / **$6,000** Family	The **out-of-pocket limit** is the most you could pay during a coverage period (usually one year) for your share of the cost of covered services. This limit helps you plan for health care expenses.
What is not included in the out-of-pocket limit?	Premium, balance-billed charges, health care this plan doesn't cover.	Even though you pay these expenses, they don't count toward the **out-of-pocket limit**.
Is there an overall annual limit on what the plan pays?	No, this policy has no overall annual limit on the amount it will pay each year.	The chart starting on page 2 describes any limits on what the plan will pay for *specific* covered services, such as office visits.
Does this plan use a network of providers?	Yes. For a list of **participating providers**, see www.welcometouhc.com/uhcwest or call 1-800-624-8822.	If you use a **participating** doctor or other health care **provider,** this plan will pay some or all of the costs of covered services. Be aware, your **participating** doctor or hospital may use a non-participating **provider** for some services. Plans use the term **in-network**, **preferred**, or **participating** to refer to **providers** in their **network**. See the chart starting on page 2 for how this plan pays different kinds of **providers**.
Do I need a referral to see a specialist?	Yes, written or oral approval is required, based upon medical policies.	This plan will pay some or all of the costs to see a **specialist** for covered services but only if you have the plan's permission before you see the **specialist**.
Are there services this plan doesn't cover?	Yes	Some of the services this plan doesn't cover are listed on page 5. See your policy or plan document for additional information about **excluded services**.

Questions: Call 1-800-624-8822 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the telephone numbers above to request a copy.

- **Co-payments** are fixed dollar amounts (for example, $15) you pay for covered health care, usually when you receive the service.
- **Co-insurance** is *your* share of the costs of a covered service, calculated as a percent of the **allowed amount** for the service. For example, if the plan's **allowed amount** for an overnight hospital stay is $1,000, your **co-insurance** payment of 20% would be $200. This may change if you haven't met your **deductible**.
- The amount the plan pays for covered services is based on the **allowed amount**. If a non-participating **provider** charges more than the **allowed amount**, you may have to pay the difference. For example, if a non-participating hospital charges $1,500 for an overnight stay and the **allowed amount** is $1,000, you may have to pay the $500 difference. (This is called **balance billing**.)
- This plan only covers services if rendered by participating **providers**. Exceptions include emergency services as described in your policy.

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you visit a health care provider's office or clinic	Primary care visit to treat an injury or illness	$20 copay per visit	Not Covered	If you receive services in addition to office visit, additional copays or co-ins may apply.
	Specialist visit	$20 copay per visit	Not Covered	Member is required to obtain a referral to specialist or other licensed health care practitioner, except for OB/GYN Physician services and Emergency / Urgently needed services. If you receive services in addition to office visit, additional copays or co-ins may apply.
	Other practitioner office visit	Not Covered	Not Covered	No coverage for manipulative (chiropractic) services.
	Preventive care / screening / immunization	No Charge	Not Covered	Includes preventive health services specified in the health care reform law.
If you have a test	Diagnostic test (x-ray, blood work)	No Charge	Not Covered	None
	Imaging (CT / PET scans, MRIs)	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you need drugs to treat your illness or condition Refer to your pharmacy plan for coverage details.	Formulary Generic – Your Lowest-Cost Option	Not Covered	Not Covered	Refer to your pharmacy plan for coverage details.
	Formulary Brand – Your Midrange-Cost Option	Not Covered	Not Covered	
	Non-Formulary – Your Highest-Cost Option	Not Covered	Not Covered	
	Specialty Medications – Additional High-Cost Options	Not Covered	Not Covered	
If you have outpatient surgery	Facility fee (example: ambulatory surgery center)	No Charge	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None
If you need immediate medical attention	Emergency room services	$50 copay per visit	$50 copay per visit	Copay waived if admitted.
	Emergency medical transportation	No Charge	No Charge	None
	Urgent care	$20 copay per visit	$50 copay per visit	Copay waived if admitted. If you receive services in addition to urgent care, additional copays or co-ins may apply.
If you have a hospital stay	Facility fee (example: hospital room)	No Charge	Not Covered	None
	Physician / surgeon fees	No Charge	Not Covered	None

Common Medical Event	Services You May Need	Your cost if you use a Participating Provider	Your cost if you use a Non-Participating Provider	Limitations & Exceptions
If you have mental health, behavioral health, or substance abuse needs	Mental / Behavioral health outpatient services	$20 copay per visit	Not Covered	None
	Mental / Behavioral health inpatient services	No Charge	Not Covered	None
	Substance use disorder outpatient services	No Charge	Not Covered	None
	Substance use disorder inpatient services	No Charge	Not Covered	None
If you are pregnant	Prenatal and postnatal care	No Charge	Not Covered	Additional copays or co-ins may apply depending on services rendered. Routine pre-natal care is covered at No Charge. Your cost in this category includes Physician Delivery Charges.
	Delivery and all inpatient services	No Charge	Not Covered	Additional copays or co-ins may apply. Your cost for inpatient services only. Delivery see above.
If you need help recovering or have other special health needs	Home health care	No Charge	Not Covered	Limited to 100 visits per calendar year.
	Rehabilitation services	$20 copay per visit	Not Covered	Coverage is limited to physical, occupational, and speech therapy.
	Habilitative services	Not Covered	Not Covered	No coverage for Habilitative services.
	Skilled nursing care	No Charge	Not Covered	Up to 100 days per benefit period.
	Durable medical equipment	No Charge	Not Covered	None
	Hospice service	No Charge	Not Covered	None
If your child needs dental or eye care	Eye exam	$20 copay per visit	Not Covered	1 exam every 12 months.
	Glasses	Not Covered	Not Covered	None
	Dental check-up	Not Covered	Not Covered	No coverage for Dental check-ups.

Excluded Services & Other Covered Services:

Services Your Plan Does NOT Cover (This isn't a complete list. Check your policy or plan document for other excluded services.)		
• Acupuncture	• Dental care (Child)	• Private-duty nursing
• Chiropractic care	• Infertility treatment	• Routine foot care
• Cosmetic surgery	• Long-term care	• Weight loss programs
• Dental care (Adult)	• Non-emergency care when traveling outside the U.S.	

Other Covered Services (This isn't a complete list. Check your policy or plan document for other covered services and your costs for these services.)		
• Bariatric surgery – Limitations may apply	• Hearing aids – Limitations may apply	• Routine eye care (Adult) – Limitations may apply

Your Rights to Continue Coverage:

If you lose coverage under the plan, then, depending upon the circumstances, Federal and State laws may provide protections that allow you to keep health coverage. Any such rights may be limited in duration and will require you to pay a **premium**, which may be significantly higher than the premium you pay while covered under the plan. Other limitations on your rights to continue coverage may also apply.

For more information on your rights to continue coverage, contact the plan at 1-800-624-8822. You may also contact your state insurance department, the U.S. Department of Labor, Employee Benefits Security Administration at 1-866-444-3272 or http://www.dol.gov/ebsa, or the U.S. Department of Health and Human Services at 1-877-267-2323 x61565 or http://www.cciio.cms.gov.

Your Grievance and Appeals Rights:

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to **appeal** or file a **grievance**. For questions about your rights, this notice, or assistance, you can contact your human resource department or the Employee Benefits Security Administration at 1-866-444-3272 or www.dol.gov/ebsa/healthreform or Department of Managed Health Care at 1-888-466-2219 or http://www.healthhelp.ca.gov.

Additionally, a consumer assistance program may help you file your **appeal**. Contact California Department of Managed Health Care Help Center at 1-888-466-2219 or http://www.healthhelp.ca.gov. A list of states with Consumer Assistance Programs is available at www.dol.gov/ebsa/healthreform and http://cciio.cms.gov/programs/consumer/capgrants/index.html.

Does this Coverage Provide Minimum Essential Coverage?

The Affordable Care Act requires most people to have health care coverage that qualifies as "minimum essential coverage." **This plan or policy does provide minimum essential coverage.**

Does this Coverage meet the Minimum Value Standard?

The Affordable Care Act establishes a minimum value standard of benefits of a health plan. The minimum value standard is 60% (actuarial value). **This health coverage does meet the minimum value standard for the benefits it provides.**

Language Access Services:

SPANISH (Español): Para obtener asistencia en Español, llame al 1-800-624-8822.
TAGALOG (Tagalog): Kung kailangan ninyo ang tulong sa Tagalog tumawag sa 1-800-624-8822.
CHINESE (中文): **如果需要中文的帮助**，请拨打这个号码 1-800-624-8822.
NAVAJO (Dine): Dinek'ehgo shika at'ohwol ninisingo, kwiijigo holne' 1-800-624-8822.

----------*To see examples of how this plan might cover costs for a sample medical situation, see the next page.* ----------

About these Coverage Examples:

These examples show how this plan might cover medical care in given situations. Use these examples to see, in general, how much financial protection a sample patient might get if they are covered under different plans.

This is not a cost estimator.

Don't use these examples to estimate your actual costs under this plan. The actual care you receive will be different from these examples, and the cost of that care also will be different.

See the next page for important information about these examples.

Having a baby
(normal delivery)

- ☐ **Amount owed to providers: $7,540**
- ☐ **Plan pays** $7,340
- ☐ **Patient pays** $200

Sample care costs:

Hospital charges (mother)	$2,700
Routine obstetric care	$2,100
Hospital charges (baby)	$900
Anesthesia	$900
Laboratory tests	$500
Prescriptions	$200
Radiology	$200
Vaccines, other preventive	$40
Total	**$7,540**

Patient pays:

Deductibles	$0
Co-pays	$0
Co-insurance	$0
Limits or exclusions	$200
Total	**$200**

Managing type 2 diabetes
(routine maintenance of a well-controlled condition)

- ☐ **Amount owed to providers: $5,400**
- ☐ **Plan pays** $1,100
- ☐ **Patient pays** $4,300

Sample care costs:

Prescriptions	$2,900
Medical Equipment & Supplies	$1,300
Office Visits and Procedures	$700
Education	$300
Laboratory tests	$100
Vaccines, other preventive	$100
Total	**$5,400**

Patient pays:

Deductibles	$0
Co-pays	$100
Co-insurance	$0
Limits or exclusions	$4,200
Total	**$4,300**

Questions and answers about Coverage Examples:

What are some of the assumptions behind the Coverage Examples?

- Costs don't include **premiums**.
- Sample care costs are based on national averages supplied to the U.S. Department of Health and Human Services, and aren't specific to a particular geographic area or health plan.
- The patient's condition was not an excluded or preexisting condition.
- All services and treatments started and ended in the same coverage period.
- There are no other medical expenses for any member covered under this plan.
- Out-of-pocket expenses are based only on treating the condition in the example.
- The patient received all care from in-participating **providers**. If the patient had received care from out-of-participating **providers**, costs would have been higher.

What does a Coverage Example show?

For each treatment situation, the Coverage Example helps you see how **deductibles**, **co-payments**, and **co-insurance** can add up. It also helps you see what expenses might be left up to you to pay because the service or treatment isn't covered or payment is limited.

Does the Coverage Example predict my own care needs?

✖ **No**. Treatments shown are just examples. The care you would receive for this condition could be different based on your doctor's advice, your age, how serious your condition is, and many other factors.

Does the Coverage Example predict my future expenses?

✖ **No**. Coverage Examples are **not** cost estimators. You can't use the examples to estimate costs for an actual condition. They are for comparative purposes only. Your own costs will be different depending on the care you receive, the prices your **providers** charge, and the reimbursement your health plan allows.

Can I use Coverage Examples to compare plans?

✓ **Yes**. When you look at the Summary of Benefits and Coverage for other plans, you'll find the same Coverage Examples. When you compare plans, check the "Patient Pays" box in each example. The smaller that number, the more coverage the plan provides.

Are there other costs I should consider when comparing plans?

✓ **Yes**. An important cost is the **premium** you pay. Generally, the lower your **premium**, the more you'll pay in out-of-pocket costs, such as **co-payments**, **deductibles**, and **co-insurance**. You should also consider contributions to accounts such as health savings accounts (HSAs), flexible spending arrangements (FSAs) or health reimbursement accounts (HRAs) that help you pay out-of-pocket expenses.

Questions: Call 1-800-624-8822 for Member Services or visit us at www.welcometouhc.com/uhcwest. If you aren't clear about any of the underlined terms used in this form, see the Glossary. You can view the Glossary at www.cciio.cms.gov or call the telephone numbers above to request a copy.

IBEW LOCAL 595 HEALTH & WELFARE PLAN ACTIVE AND RETIREE
2015 DENTAL PLAN COMPARISON

	DELTA DENTAL - ACTIVE	DELTA DENTAL - RETIREE	UNITED HEALTHCARE DENTAL Former Pacific Union Dental \ (PUD)
HOW DOES YOUR PLAN WORK?	Delta Dental PPO is a fee-for service program with freedom to choose any dentist. The Program pays a percentage for covered services; if you use a PPO Dentist, your out-of-pocket expenses are likely to decrease. Read your evidence of coverage benefits as well as the exclusions and limitations.	Delta Dental PPO is a fee-for service program with freedom to choose any dentist. The Program pays a percentage for covered services; if you use a PPO Dentist, your out-of-pocket expenses are likely to decrease. Read your evidence of coverage benefits as well as the exclusions and limitations.	United Healthcare Dental contracts with local dental professionals to provide services to you and your eligible dependants at no cost or for a low fixed co-payment.
WHO IS COVERED?	Primary enrollee, spouse and domestic partner and eligible dependent children of enrollee and spouse only to age 26.	Primary enrollee, spouse and domestic partner and eligible dependent children of enrollee and spouse only to age 26.	Primary enrollee, spouse and domestic partner and eligible dependent children of enrollee and spouse only to age 26.
DEDUCTIONS & BENEFIT MAXIMUM	$25 Individual or $75 Family deductible per calendar year. Preventive services from a PPO dentist are exempt from this deductible. The maximum benefit paid per calendar yr is $2,000 per person	25 Individual or $75 Family deductible per calendar year. Preventive services from a PPO dentist are exempt from this deductible. The maximum benefit paid per calendar yr is $2,000 per person	No yearly maximums
DIAGNOSTIC & PREVENTATIVE BENEFITS *oral examinations cleanings, x-rays, biopsy/tissue examinations, fluoride treatment space maintainers, specialist consultation.	100% of Delta's Contract Allowance	100% of Delta's Contract Allowance	No charge
BASIC BENEFITS Oral Surgery (extractions), filings, root canals, periodontal (gum) treatment, sealants, oral surgery (extractions). tissue removal (biopsy)	80% of Delta 's Contract Allowance	80% of Delta's Contract Allowance	No charge
CROWNS, OTHER CAST RESTORATIONS **Crowns, inlays, onlays and cast restorations**	80% of Delta's Contract Allowance	80% of Delta's Contract Allowance	No charge
PROSTHODONTIC BENEFITS Bridges, partial dentures, full dentures,	80% of Delta's Contract Allowance	80% of Delta's Contract Allowance	No charge
ORTHODONTIC BENEFITS* *For adults and dependent children w/UHC Dental available to dependants only between ages of 10 & 19 *Delta Dental only covers children to the age of 19.	80% of Delta's Contract Allowance (subject to a $2,500 lifetime maximum per person)	80% of Delta's Contract Allowance (subject to a $2,500 lifetime maximum per person)	One-time surcharge of $750 $350 start-up fees $150 for 1-set retainers

Rev Date: 1/07/2015

DELTA DENTAL PPO℠: YOUR SMILE IS COVERED

GO PPO!
You can visit any licensed dentist under this plan, but you'll maximize plan value by selecting a Delta Dental PPO[1] dentist. PPO network dentists have agreed to reduced contracted rates and can't "balance bill" you for additional fees.[2] Find a dentist at **deltadentalins.com**.[3]

CONVENIENT ONLINE SERVICES: DELTADENTALINS.COM
- Create a free Online Services account from your PC or smartphone to view benefits, eligibility and claims status or check average dental costs in your area.
- Update your dental benefit statement delivery preference: Go paperless!
- Find a Delta Dental PPO dentist near you.

NO ID CARD NECESSARY
Just provide your dental office with your name, birth date and enrollee ID or social security number. Register for Online Services to print an ID card or pull it up on your smartphone at the dentist's office.

HASSLE-FREE TRANSITION & EASY BENEFITS COORDINATION
New to Delta Dental PPO? This plan covers treatment started and completed after your plan's effective date of coverage.[4] If you're covered under two plans, ask your dentist to include information about both plans with your claim, and we'll handle the rest.

SAVE WITH A PPO DENTIST

DELTA DENTAL PPO

NON-DELTA DENTAL DENTISTS

LEGAL NOTICES: Access federal and state legal notices related to your plan: deltadentalins.com/about/legal/index-enrollee.html

[1] In Texas, Delta Dental Insurance Company offers a Dental Provider Organization (DPO) plan.

[2] Enrollees are responsible for any coinsurance, deductible, amount over the plan maximum and charges for non-covered services.

[3] Verify that your dentist is a contracted Delta Dental PPO network dentist before each appointment.

[4] Applies only to procedures covered under your plan. If you began treatment prior to your effective date of coverage, you or your prior carrier will be responsible for any costs. Group- and state-specific exceptions may apply. Enrollees currently undergoing active orthodontic treatment may be eligible to continue treatment under Delta Dental PPO. Review your Evidence of Coverage, Summary Plan Description or Group Dental Service Contract for specific details about your plan.

DELTA DENTAL®

WE KEEP YOU SMILING®

Plan Benefit Highlights for: IBEW Local 595 Health & Welfare Trust
Group No: 03374

DELTA DENTAL PPO℠

BENEFIT HIGHLIGHTS

Eligibility	Primary enrollee, spouse (includes domestic partner) 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 / $75 per family each calendar year Yes: PPO Dentists only No: Non-PPO Dentists			
Maximums	$2,000 per person each calendar year			
Waiting Period(s)	Basic Benefits None	Major Benefits None	Prosthodontics None	Orthodontics None

Benefits and Covered Services*	Delta Dental PPO dentists**	Non-Delta Dental PPO dentists**
Diagnostic & Preventive Services (D & P) Exams, cleanings and x-rays	100 %	100 %
Basic Services Fillings, simple tooth extractions and sealants	80 %	80 %
Endodontics (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 Crowns, inlays, onlays and cast restorations	80 %	80 %
Prosthodontics Bridges, dentures and implants	80 %	80 %
Orthodontic Benefits Adults and dependent children	80 %	80 %
Orthodontic Maximums	$ 2,500 Lifetime	$ 2,500 Lifetime

* 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.

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

Delta Dental of California
100 First St.
San Francisco, CA 94105

Customer Service
800-765-6003

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

deltadentalins.com

This benefit information is not intended or designed to replace or serve as the plan's Evidence of Coverage or Summary Plan Description. If you have specific questions regarding the benefits, limitations or exclusions for your plan, please consult your company's benefits representative.

Most Common Questions

WHAT IS A "MANAGED CARE" DENTAL PLAN?

A "Managed Care" dental plan contracts directly with licensed dental professionals to deliver quality dental care to its members.

HOW TO USE YOUR PLAN?

General Dental Services: Please select a dental office from the list of contracted Plan providers and indicate the dental office and ID# on the enrollment form. The Plan will assist you in selecting a dentist whenever you request such assistance. Thereafter, to obtain services, you need only contact the selected Plan provider and make an appointment. In the event you are dissatisfied with any Plan provider selected, for any reason, and desire to transfer to another, you may do so by contacting the Plan prior to the 20th of the month and the transfer will be effective the first day of the following month.

Specialty Services: Should your treatment plan require the services of a specialist you will be referred by your Plan provider. All benefits and copayments apply to specialty services provided the referral has the prior approval of the Plan's Dental Director. If you need assistance with obtaining a specialty referral, please contact the Customer Care Department listed below.

Emergency Services or Urgent Care: Should you need urgent care, or are experiencing a dental emergency, please contact your Plan provider and indicate that you are in need of urgent or emergency care. If you need assistance with obtaining emergency or urgent care from your Plan provider, or are out of the area, you may contact Customer Care at the toll-free number listed on your dental ID card during normal business hours to arrange for out-of-area emergency care.

After Hours Care: If you need services after hours, first contact your assigned Plan provider. Plan providers are required to have 24-hour access to on-call care. If you are unable to contact your Plan provider, this plan provides for reimbursement for any emergency or after hours care out of the area up to $100, less any usual copayments required for any procedures performed on a fee-for-service basis. If you need such care after hours, you must notify the Plan within 48 hours of receiving care from a non-participating provider.

Out-of-Area Care: To receive dental care out of your area, first contact Customer Care at the toll-free number listed on your dental ID card to determine if you can be served by another contracted Plan provider. If you are more than 50 miles from a contracted Plan provider, you may be directed to seek care from a non-Plan provider. If you need services after hours, please refer to the above After Hours Care section.

WHAT ARE THE BENEFITS?

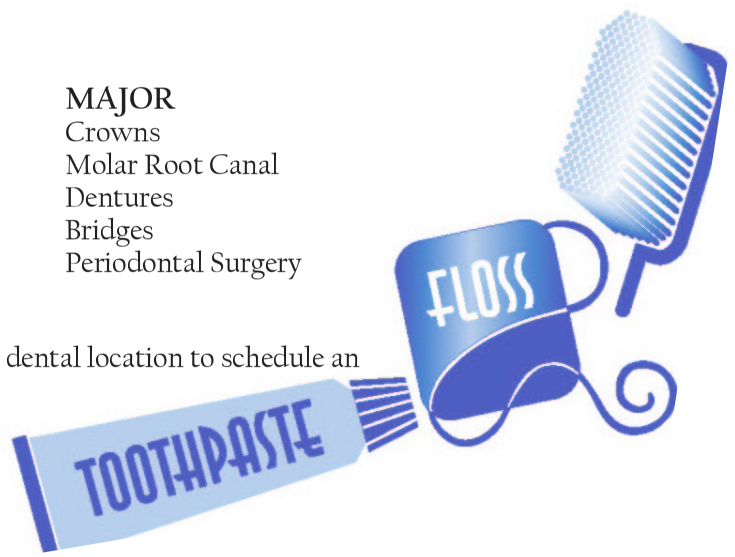
PREVENTIVE	BASIC	MAJOR
Exams	Fillings	Crowns
Cleanings	Simple Extractions	Molar Root Canal
X-rays		Dentures
		Bridges
		Periodontal Surgery

HOW IS CARE RECEIVED?

The member may receive care by simply calling the selected dental location to schedule an appointment. There are no forms or cards required.

WHAT ABOUT MISSED APPOINTMENTS?

If a member fails to cancel an appointment at least 24 hours in advance, a "failed appointment fee" will be charged and no further appointments will be made until the cancellation fee is paid.



PUD -7193 (10/08)

PACIFIC UNION DENTAL℠
A Dental Benefit Providers of California, Inc. Product.

Benefit Schedule

HOW DOES YOUR DENTAL PLAN WORK?

Dental Benefit Providers of California, Inc. ("DBP-CA") has created a Plan that offers our members quality dental health services at a significant savings. We have contracted with quality, local dental professionals to provide services to you and your eligible dependents at no cost or for low fixed copayments. The following is an example of the potential savings on a typical case.

	PUD	Usual & Customary Fees
Office Exam & X-rays	No Charge	$45
Cleanings (2) - one every 6 months	No Charge	$90

TAKE ADVANTAGE OF THE BENEFITS

In addition to substantial savings, there are many other advantages as described in this brochure. Under this plan, there are **no claim forms** to complete, **no deductibles** to be met and **no yearly dollar maximum** of coverage.

MEMBERSHIP ELIGIBILITY

This plan is designed for the employee and, if eligible, his/her family. Unless stated otherwise by your group, coverage is extended to the spouse and/or unmarried dependent children. Dependent children include: 1. All natural, 2. Adopted, 3. Step-children. An unmarried dependent child will be eligible to their 19th birthday, or age 23 if a full-time student (or subject to age limitations established by group or organization). Automatic coverage is provided for mentally and/or physically challenged dependent children.

CHOOSE YOUR DENTIST AND OFFICE

You and your family choose your dentist from a wide network of private dental offices. A list of dental offices is provided to permit each member to choose the most convenient office. The member and dependents may select different dental offices. If so desired, you may transfer to a different Plan office. Simply notify the Plan prior to the 20th of the month and the transfer will be effective the first day of the following month.

OTHER BENEFITS

• Maximum benefits allowed annually per person are unlimited • No deductibles • No claim forms required
• You know your exact "out-of-pocket" costs, if any • You may select the participating dentist of your choice.

ENROLLMENT PROCEDURE

Simply fill out and return the enclosed enrollment form to your Benefits Administrator at your place of employment or return it to your Trust Fund Office.

OTHER CHARGES

The member pays the copayments listed on the Benefit Copayment Schedule for each dental procedure completed by the dentist. These fees must be paid directly to the participating dental office where the dental treatment is received. Payments are due on the day of service unless prior arrangements have been made with your dental provider.

TERMINATION OF BENEFITS

1. On expiration date of dental coverage.
2 When a dependent member gets married, attains the age of 19 or ceases to be a full-time student prior to age 23 or subject to age limitations established by group or organization.
3. Permitting or committing fraud. In the event of termination, the Plan provider shall complete any procedures listed on the Benefit Copayment Schedule commenced prior to the termination date, and the member is required to pay all copayments in accordance with the Benefit Copayment Schedule.
4. Members who violate the Plan's rules may have their benefits suspended or be transferred to an indemnity plan.

ORTHODONTICS

Orthodontic benefits are available to most groups. Coverage varies by area and policy purchased. A seperate Orthodontic Benefit Schedule, if not included, is available from the Plan office. Coverage to orthodontics applies to Phase II treatment only.

NOBLE MATERIALS (GOLD)

If noble materials, not normally prescribed, are requested for fillings, crowns, bridges, or prosthetic devises, there will be an additional charge based on the amount of metal used.

BASIC METHOD OF REIMBURSEMENT

The Plan contracts with general and specialized dentists to provide quality dental services for eligible group members. The Plan compensates its providers using direct reimbursement, discounted fee-for-service, fee-for-service or capitation. The Plan does not use provider incentives or bonus plans to influence specific dental care decisions.

SECOND OPINION

If the member has a treatment question or concern that cannot be addressed by the member's current Plan provider and/or the Plan's Dental Director, the member may request a second opinion from another Plan dentist. There is no cost for this second opinion except for applicable copayments, if any. The second opinion will be performed by a contracted Plan general dentist or specialist. A second opinion must be arranged through the Customer Care Department by calling 1-800-999-3367.

ACUTE CARE

The Plan is responsible for immediately providing emergency dental services to our members upon enrollment in our dental plan. Emergency services are subject to the limitations and exclusions found in your evidence of coverage.

BINDING ARBITRATION

In the event you are unable to utilize the "binding arbitration" provision contained in the contract because you believe it will cause you "extreme financial hardship," you may request financial assistance from the Plan. Eligible enrollees may request a copy of the Plan's written policy which includes information on how enrollees may request financial assistance in order to exercise all of their rights under this policy.

CONTINUITY OF CARE

You may have a qualified right to continue care with a previous provider for a designated period of time in some situations. The Plan is in compliance with all state laws involving Continuity of Care Rights. A copy of the Plan's Continuity of Care policy is available upon request from Customer Care.

GRIEVANCE PROCEDURE

Any complaints may be referred to the Plan's Customer Care Department by calling **1-800-999-3367**. Complaint forms and a copy of the grievance procedure are available from the Plan.

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan at **1-800-999-3367** and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-HMO-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

DBP-CA does not discriminate or tolerate discrimination of any kind against an enrollee who has filed a complaint with the Plan of any kind (i.e. against a provider or the Plan itself, or any other complaint). No Plan contract shall be cancelled because an enrollee filed a complaint with the Plan.

PRINCIPAL LIMITATIONS

Set forth below are the limitations that are applicable to this Plan:

1. Prophylaxis is limited to one treatment each six-month period (including periodontal maintenance following active therapy).
2. Crowns, bridges and dentures (including immediate dentures) are not to be replaced within a five-year period from initial placement regardless of payor. Adjustments to crowns, bridges, and dentures are included in the coverage for the appliance for the first 6 months after initial placement.
3. Partial dentures (including interim partial dentures, resin-based partial dentures, and metal-framework partial dentures) are not to be replaced within any five-year period from initial placement, unless necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible; an interim partial denture (5820 or 5821) may be replaced with a covered partial denture (5211, 5212, 5213 or 5214) no more than one time in a five-year period from the placement of the interim partial denture (also known as "stayplate").
4. Denture relines are limited to one per denture (including immediate dentures) during any 12 consecutive months.
5. Replacement will be provided for an existing denture, partial denture or bridge only if it is unsatisfactory and cannot be made satisfactory by reline or repair.
6. The plan allows up to five units of crown or bridgework per arch within a 5-year period. Upon the sixth unit, the Plan considers the treatment to be full mouth reconstruction. The patient is responsible for fees incurred for anything beyond the fifth unit within any five-year period.
7. Non-surgical periodontal treatments (including but not limited to root planing/subgingival curettage) are limited to four quadrants during any 12 consecutive months. Surgical procedures are limited to one treatment per quadrant or area during any 36 consecutive months.
8. Full mouth debridement (gross scale) is limited to one treatment in any 24 consecutive month period.
9. Bitewing x-rays are limited to not more than one series in any six-month period.
10. Full mouth x-rays and panoramic type films are limited to one set every 24 consecutive months. A full mouth x-ray is defined as a minimum of 6 periapical films plus bitewing x-rays.
11. Sealant benefits include the application of sealants to permanent first and second molars and bicuspids with no decay, with no restorations and with the occlusal surface intact up to age fourteen. Sealant benefits do not include the repair or replacement of a sealant on any tooth within three years of its application.
12. Single unit cast metal and/or ceramic restorations and crowns are covered only when the member is 17 years of age or older, and the tooth cannot be adequately restored with other restorative materials. Crown build-ups including pins are only allowable as a separate procedure in the exceptional instance where extensive tooth structure is lost and the need for a substructure can be demonstrated by written report and x-rays. An allowance is made for pre-fabricated crown for children 16 and under.
13. Referral to a dental specialist (if covered) is limited to only those covered procedures that cannot be performed by a contracted general dentist, as determined by the Plan's Dental Director.
14. Third-molar ("wisdom teeth") extraction is limited to only those instances where the teeth cannot be treated in a more conservative manner.
15. Use of cosmetic materials is limited to anterior and posterior composite restorations (including composite restorations on the facial surfaces of premolar teeth), and porcelain-fused-to-metal cast crown restorations on posterior teeth due to decay or fracture. All other cosmetic or esthetic care is excluded from coverage.
16. The Plan benefits cast restoration using predominantly base metal. If the member requests noble or high noble metal be used (e.g., gold, semi-precious metals, etc.), the member may be charged a surcharge based on the additional laboratory charges for such metals.
17. OPTIONAL DENTAL TREATMENT: Listed copayments apply for services ONLY when prescribed by a contracted dentist as a necessary, adequate and appropriate procedure for your dental condition. In some cases there may be more than one appropriate procedure or option to address a dental condition. Optional Dental Treatment is defined as any procedure that is a dental laboratory upgrade of a standard covered service (members may be charged a surcharge based on the additional laboratory costs); OR a more extensive covered service that is an alternative to an adequate, but more conservative, covered dental service. If a member selects a more extensive form of treatment than is recommended by the contracted dentist or that is alternative to an adequate, but more conservative covered dental service, the member may be charged the difference between the contracted dental office's usual fee for the more extensive form of treatment, and the usual fee for the covered treatment, plus the copayment for the covered benefit as listed in the benefit schedule.

PRINCIPAL EXCLUSIONS

The following procedures and services are not included in the Plan:

1. General anesthesia and the services of a special anesthesiologist, intravenous and inhalation sedation and prescription drugs.
2. Dental conditions arising out of and due to enrollee's employment or for which Worker's Compensation is payable, or any other third-party is liable. Services that are provided to the enrollee by state government or agency thereof, or are provided without cost to the enrollee by any municipality, county or other subdivision, except as provided in Section 1373 (a) of the California Health and Safety Code.
3. Benefits do not include splinting, hemisection, implants, overdentures, grafting (unless otherwise stated), guided tissue regeneration, all-ceramic cast restorations, precision attachments, duplicate dentures, and appliances for the treatment of bruxism.
4. Dental services and any related fees performed in a treatment facility other than the contracted provider's office (i.e. hospital, ambulatory care facility, outpatient clinic, surgical center, etc.).
5. Treatment of fractures and/or dislocations of the jaws.
6. Loss or theft of fixed and/or removable prosthetics (crowns, bridges, full or partial dentures) regardless of payor.
7. Dental expenses incurred in connection with any dental procedures started after termination of eligibility for coverage; and dental expenses incurred for treatment in progress prior to Member's eligibility with the Plan (e.g.: teeth prepared for crowns, root canals in progress, fixed or removable prosthetics). Crowns, bridges or dentures started in one office (while under PUD coverage) are considered "in progress" until delivered. Additional benefits will not be provided for such treatment in progress.
8. The Schedule of Benefits of procedures is the definitive statement of coverage, and supersedes all other materials. Any service that is not specifically listed as a covered benefit is excluded from coverage, regardless of any other written material presented or implied.
9. Procedures, appliances or restorations to correct congenitally and/or developmentally missing teeth or other congenital and/or developmental conditions, developmental malformations (including but not limited to cleft palate, enamel hypoplasia, fluorosis, jaw malformations, anodontia) and supernumerary teeth.
10. Treatment/removal of malignancies, cysts, tumors or neoplasms.
11. Dispensing of drugs not associated with a course of dental care, such as medicinal irrigation, locally administered antibiotics and prescription drugs.
12. Crowns, bridges and/or dentures placed as a definitive restoration of tooth structure lost as a result of accidental injury. Accidental injury is defined as damage to the hard or soft tissues of the oral cavity resulting from external forces to the mouth. Treatment for all accident-related services payable by another liability carrier, other than a dental plan. (NOTE: "Definitive" refers to a "final" or "permanent" appliance or treatment.)
13. Cases which in the professional opinion of the Plan's attending dentist or Dental Director it is determined that a satisfactory result cannot be obtained or where the prognosis is poor or guarded (i.e. without a minimum service expectancy of 3 years).
14. Dental services received from any dental office other than a Plan's dental office, unless expressly authorized in writing by the Plan or as cited under "Out of Area Emergency Treatment."
15. Removal of asymptomatic teeth, nonpathological teeth, extractions for orthodontic purposes; surgical orthognatic procedures and crown exposure with or without ligation.
16. Implant placement or removal, appliances placed on or services associated with implants, including but not limited to prophylaxis and periodontal treatment.
17. Crown lengthening procedures.
18. Replacement of long-standing missing tooth/teeth in an otherwise stable dentition. (Example: teeth missing two years or longer, not currently replaced, and where adjacent and opposing teeth are in occlusion).
19. Dental services and treatments for restoring tooth structure loss from abnormal or excessive wear or attrition, abrasion, abfraction, bruxism, and/or erosion, except when due to normal masticatory function; changing or restoring vertical dimension, or occlusion, and full mouth reconstruction, diagnosis and/or treatment of the temporomandibular joint (TMJ).
20. Dental services that cannot be performed in the Plan's general dental office because of physical, medical or behavioral limitations of eligible enrollees over the age of seven years.
21. Pathology reports are excluded from coverage.

Pacific Union Dental
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IMPERIAL

DIRECT COMPENSATION

ADA	DESCRIPTION	MEMBER'S COPAYMENT
	DIAGNOSTIC SERVICES	
00120	Periodic Oral Exam-Established Patient	0
00140	Limited Oral Evaluation-Focused	0
00145	Oral Evaluation-Pt Under 3 yrs/Counseling	0
00150	Comprehensive Oral Evaluation	0
00160	Detailed & Extensive Oral Examination	0
00170	Re-evaluation – Limited	0
00180	Comprehensive Periodontal Eval	0
00210	Intraoral-Complete (Inc. Bitewings)	0
00220	Intraoral-Periapical First Film	0
00230	Intraoral-Periapical Each Additional	0
00240	Intraoral-Occlusal Film	0
00250	Extraoral-First Film	0
00260	Extraoral-Each Additional Film	0
00270	Bitewings-Single Film	0
00272	Bitewings-Two Films	0
00273	Bitewings-Three Films	0
00274	Bitewings-Four Films	0
00277	Vertical Bitewings - 7 to 8 Films	0
00330	Panorex Film	0
00340	Cephalometric Film	0
00421	Genetic Test for Subscep to Oral Dis	0
00425	Caries Susceptibility Tests	0
00460	Pulp Vitality Tests	0
00470	Diagnostic Casts	0
	PREVENTIVE SERVICES	
01110	Prophylaxis, Adult	0
01120	Prophylaxis, Child	0
01203	Topical Fluoride w/o Prophy - Child	0
01204	Topical Fluoride w/o Prophy - Adult	0
01206	Topical Fluoride Varnish	0
01310	Nutritional Counseling	0
01320	Tobacco Counseling	0
01330	Oral Hygiene Instruction	0
01351	Sealant, Per Tooth	5
01510	Space Maintainer-Fixed-Unilateral	0
01515	Space Maintainer-Fixed-Bilateral	0
01520	Space Maintainer-Rem-Unilateral	0
01525	Space Maintainer-Rem-Bilateral	0
01550	Recementation of Space Maintainer	0
01555	Removal of Fixed Space Maintainer	0
	BASIC RESTORATIVE SERVICES	
02140	Amalgam 1 Surface	0
02150	Amalgam 2 Surfaces	0
02160	Amalgam 3 Surfaces	0
02161	Amalgam 4 or More Surfaces	0
02330	Resin Composite - 1 Surface, Ant	0
02331	Resin Composite - 2 Surfaces, Ant	0
02332	Resin Composite - 3 Surfaces, Ant	0
02335	Resin Comp 4+ Surf or Inc Edge, Ant	0
	ADVANCED RESTORATIVE SRVS	
02710	Crown-Resin Based Comp Indirect*	0
02712	Crown 3/4 Resin Based Comp Indirect*	0
02720	Crown-Resin With High Noble Metal*	0
02721	Crown-Resin w/Predom Base Metal*	0
02722	Crown-Resin With Noble Metal*	0
02740	Crown-Porcelain/Ceramic Substrate*	0
02750	Crown-Porc Fused/High Noble Metal*	0
02751	Crown-Porc Fused/Pred Base Metal*	0
02752	Crown-Porc Fused To Noble Metal*	0
02780	Crown-3/4 Cast High Noble Metal*	0
02781	Crown-3/4 Cast/Predom Base Metal	0
02782	Crown-3/4 Cast Noble Metal*	0
02783	Crown-3/4 Porcelain/Ceramic*	0
02790	Crown-Full Cast High Noble Metal*	0
02791	Crown-Full Cast/Predom Base Metal	0
02792	Crown-Full Cast Noble Metal*	0
02794	Crown-Titanium*	0
02910	Recement Inlay/Onlay/Partial Cov Rest	0
02915	Recement Cast/Prefab Post & Core	0
02920	Recement Crown	0
02930	Prefab. Stain. St. Crown Prim	0
02931	Prefab. Stain. St. Crown Perm	0
02932	Prefab. Resin Crown*	0
02934	Prefab Esthetic Coat Stain St Crn Prim*	0
02940	Sedative Fillings	0
02950	Core Build-up, Including Pins	0
02951	Pin Retention - Per Tooth, w/Rest	0
02952	Cast Post/Core In Add To Crown, Ind Fab	0
02953	Ea Add Indirect Fab Post-Same Tooth	0
02954	Prefab/Post & Core In Add To Crown	0
02957	Ea Add Prefab Post-Same Tooth	0
02970	Temporary Crown (Fractured Tooth)	0
	ENDODONTIC SERVICES	
03110	Pulp Cap-Direct (w/o Final Rest)	0
03120	Pulp Cap-Indirect (w/o Final Rest)	0
03220	Therapeutic Pulp (w/o Final Rest)	0
03221	Gross Pulpal Debridement	0
03230	Pulpal Therapy Anterior Primary	0
03240	Pulpal Therapy Posterior Primary	0
03310	Root Canal, Anterior (w/o Final Rest)	0
03320	Root Canal, Bicuspid (w/o Final Rest)	0
03330	Root Canal, Molar (w/o Final Rest)	0
03332	Inc Endo Ther, Inoper/Unrest/Fx Tooth	0
03346	Retreatment Previous RCT - Anterior	0
03347	Retreatment Previous RCT - Bicuspid	0
03348	Retreatment Previous RCT - Molar	0
03351	Apexification, Initial Visit	0
03410	Apicoectomy, Anterior	0
03421	Apicoectomy, Bicuspid (First Root)	0
03425	Apicoectomy, Molar (First Root)	0
03426	Apicoectomy, Each Additional Root	0
03430	Retrograde Filling (Per Root)	0
03450	Root Amputation (Per Root)	0
03920	Hemisection (Inc Root Rem) w/o RCT	0
	PERIODONTAL SERVICES	
04210	Gingivectomy/Gingivoplasty (4+ Teeth)	0
04211	Ging or Gingivoplasty (1-3 Teeth)	0
04240	Ging Flap w/Root Planing (4+ Teeth)	0
04241	Gingival Flap With Rp (1 to 3 Teeth)	0
04260	Osseous Surgery (4+ Teeth)	0
04261	Osseous Surgery (1 to 3 Teeth)	0
04263	Bone Replacement Graft-1st Site/Quad	0
04264	Bone Rep Graft-Ea Add Site in Quad	0

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ADA	DESCRIPTION	MEMBER'S COPAYMENT
04270	Pedicle Soft Tissue Graft Procedure	0
04271	Free Soft Tissue Gr w/Donor Site Surg	0
04274	Distal/Proximal Wedge Procedure	0
04341	Perio Scaling & RP (4+ Teeth)	0
04342	Perio Scale & RP (1 to 3 Teeth)	0
04910	Perio. Maint. Procedure	0
	REMOVABLE PROSTHODONTICS	
05110	Complete Denture - Maxillary	0
05120	Complete Denture - Mandibular	0
05130	Immediate Denture - Maxillary	0
05140	Immediate Denture - Mandibular	0
05211	Maxillary Partial Denture-Resin Base	0
05212	Mandibular Partial Denture-Resin Base	0
05213	Max Partial Denture-Cast Mtl Frame*	0
05214	Mand Partial Denture-Cast Mtl Frame*	0
05225	Max Partial Denture-Flexible Base*	0
05226	Mand Partial Denture-Flexible Base*	0
05410	Adjust Complete Denture - Maxillary	0
05411	Adjust Complete Denture - Mandibular	0
05421	Adjust Partial Denture - Maxillary	0
05422	Adjust Partial Denture - Mandibular	0
05510	Repair Broken Complete Denture Base	0
05520	Rep Missing/Broken Teeth- Per Tooth	0
05610	Repair Resin Denture Base	0
05620	Repair Cast Framework	0
05630	Repair Or Replace Broken Clasp	0
05640	Replace Broken Teeth-Per Tooth	0
05650	Add Tooth to Existing Partial Denture	0
05660	Add Clasp to Existing Partial Denture	0
05670	Replace All Teeth - Maxillary	0
05671	Replace All Teeth - Mandibular	0
05710	Rebase Complete Maxillary Denture	0
05711	Rebase Complete Mandibular Denture	0
05720	Rebase Maxillary Partial Denture	0
05721	Rebase Mandibular Partial Denture	0
05730	Reline Comp Maxillary Denture- Chair	0
05731	Reline Comp Mandibular Denture-Ch	0
05740	Reline Maxillary Partial Denture-Chair	0
05741	Reline Mandibular Partial Denture-Ch	0
05750	Reline Complete Max Denture-Lab	0
05751	Reline Complete Mand Denture-Lab	0
05760	Reline Maxillary Partial Denture-Lab	0
05761	Reline Mand Partial Denture - Lab	0
05820	Interim Partial Denture, Maxillary	0
05821	Interim Partial Denture, Mandibular	0
05850	Tissue Conditioning, Maxillary	0
05851	Tissue Conditioning, Mandibular	0
	FIXED PROSTHODONTICS	
06205	Pontic-Indirect Resin Based Comp*	0
06210	Pontic-Cast High Noble Metal*	0
06211	Pontic-Cast Predom Base Metal	0
06212	Pontic-Cast Noble Metal*	0
06214	Pontic-Titanium*	0
06240	Pontic-Porcelain/High Noble Metal*	0
06241	Pontic-Porcelain/Predom Base Metal*	0
06242	Pontic-Porcelain/Noble Metal*	0
06245	Pontic-Porcelain/Ceramic*	0
06250	Pontic-Resin w/High Noble Metal*	0
06251	Pontic-Resin w/Predom Base Metal*	0
06252	Pontic-Resin w/Noble Metal*	0
06545	Retainer-Cast Mtl For Resin Fxd Pros	0
06548	Ret-Porc/Cer For Resin Bond Fx Pros*	0
06710	Crown-Indirect Resin Based Comp*	0
06720	Crown-Resin w/High Noble Metal*	0
06721	Crown-Resin w/Predom Base Metal*	0
06722	Crown-Resin w/Noble Metal*	0
06740	Crown-Porcelain/Ceramic*	0
06750	Crown-Porc/High Noble Metal*	0
06751	Crown-Porc/Predom Base Metal*	0
06752	Crown-Porc/Noble Metal*	0
06780	Crown-3/4 Cast High Noble Metal*	0
06781	Crown-3/4 Cast Predom Based Metal	0
06782	Crown-3/4 Cast Noble Metal*	0
06783	Crown-3/4 Porcelain/Ceramic*	0
06790	Crown-Full Cast High Noble Metal*	0
06791	Crown-Full Cast Predom Base Metal	0
06792	Crown-Full Cast Noble Metal*	0
06794	Crown-Titanium*	0
06930	Recement Fixed Partial Denture	0
06970	Post/Core-Add to Bridge Retainer-Indirect Fab	0
06972	Prefab. Post/Core-Add to Fixed Partial Ret	0
06973	Core Buildup For Retainer Inc Pins	0
06976	Each Add'l Indirectly Fab Post-Same Tooth	0
06977	Each Add Prefab Post-Same Tooth	0
	ORAL SURGERY	
07111	Ext Coronal Remnants – Prim Tooth	0
07140	Extraction-Erupted Tooth/Exp Root	0
07210	Surg Rem/Erupted Tooth-Req Elev	0
07220	Removal Impacted Tooth - Soft Tissue	0
07230	Removal Impacted Tooth - Part Bony	0
07240	Removal Imp Tooth - Complete Bony	0
07241	Rem Imp Tooth-Comp Bony w/Comp	0
07250	Surg Removal Residual Tooth Roots	0
07285	Biopsy of Oral Tissue-Hard	0
07286	Biopsy of Oral Tissue-Soft	0
07287	Exfoliative Cytological Sample Collection	0
07288	Brush Biopsy-Trans Sample Collection	0
07310	Alveol. w/Ext-4+ Teeth/Spaces, per quad	0
07311	Alveoloplasty w/Ext (1 to 3 Teeth/Sp)	0
07320	Alveol. w/o Ext-4+ Teeth/Spaces, per quad	0
07321	Alveoloplasty w/o Ext (1 to 3 Teeth/Sp)	0
07340	Vestibuloplasty-Ridge Extension	0
07350	Vestibuloplasty-Ridge Ext w/Comp	0
07510	I & D of Abscess, Intraoral Soft Tissue	0
07511	I & D of Abscess, Intraoral Comp	0
07520	I & D of Abscess, Extraoral Soft Tissue	0
07521	I & D of Abscess, Extraoral Comp	0
07530	Rem of Forgn Body-Skin/Subcutaneous	0
07960	Frenulectomy - Separate Procedure	0
07963	Frenuoplasty	0
	ADJUNCTIVE SERVICES	
09110	Palliative (Emergency) Treatment	0
09120	Fixed Partial Denture Sectioning	0
09310	Consult-Diag Srv Provided by Another DDS	0
09430	Office Visit for Observation	0
09440	Office Visit After Regular Sched Hours	25
09450	Case Presentation	0
09930	Treatment of Complications, By Report	0
09940	Occlusal Guard, By Report	25
09942	Repair/Reline of Occlusal Guard	0
09951	Occlusal Adjustment Limited	0
09952	Occlusal Adjustment Complete	0
09971	Odontroplasty	0
10001	FAILED APPOINTMENT	25

*Resin, porcelain, and any resin to metal or porcelain to metal crowns and pontics are excluded on molar teeth. If titanium, noble or high noble metals are requested for fillings, crowns, pontics, bridges, or prosthetic devices, there will be an additional charge, based on the amount of metal used. Flexible base partial dentures are subject to an additional charge based on additional laboratory cost.

TAHOE PLAN
ORTHODONTIC BENEFITS

I. ORTHODONTIC BENEFITS

Orthodontic services are provided as part of the dental benefits provided by PACIFIC UNION DENTAL, subject to the following provisions:

a) There shall be a one-time surcharge of **$750.00** for a full-banded/2 year case, (Phase II treatment only), plus an additional charge of no more than:

$350.00 for start-up fees
$150.00 for one set of retainers (with retention limited to 12 consecutive months, if necessary)

Member's payment schedule as follows unless otherwise agreed upon between the member and the orthodontist:

$250.00 at the inception of care (the placement of bands).
$50.00 per month for 10 months.

b) Orthodontic treatment is available for each eligible dependent between ages 10 and 19. Orthodontic care for dependent children over the ages of 19 is not a covered benefit.

c) Orthodontic treatment must be provided by a member of the orthodontic panel who is providing said treatment under a contract with PACIFIC UNION DENTAL.

d) Plan benefits cover 24 months of usual and customary Phase II orthodontic treatment.

II. LOSS OF BENEFIT/RESIDUAL OBLIGATIONS

Should a member be terminated or become ineligible for benefits, the member is subject to the following provisions:

a) Availability of the orthodontic benefits described herein will cease upon loss of members eligibility and/or termination of the Group Subscriber Agreement for any reason. In the event benefits terminated while members and/or dependents have treatment in progress, the member may complete treatment by payment of the lesser of the following:

1) The number of months remaining in treatment times $125 per month.
2) $3000 less any copayments (including start-up fees) paid prior to termination of this benefit.

b) If a termination of benefits occurs due to a termination of the Group Subscriber Agreement, the group shall reserve the right to assign members residual obligation as described in (a) above to a successor organization.

c) If member loses eligibility for 3 or more consecutive months they will be considered no longer eligible for orthodontic benefits, and (1) above would apply.

d) Dependents other than spouse lose benefits on the 19th birthday (subject to 1 a & b above).

III. ADDITIONAL CHARGES

a) Treatment that extends beyond 24 months will be subject to an office visit charge, which will be the members responsibility.

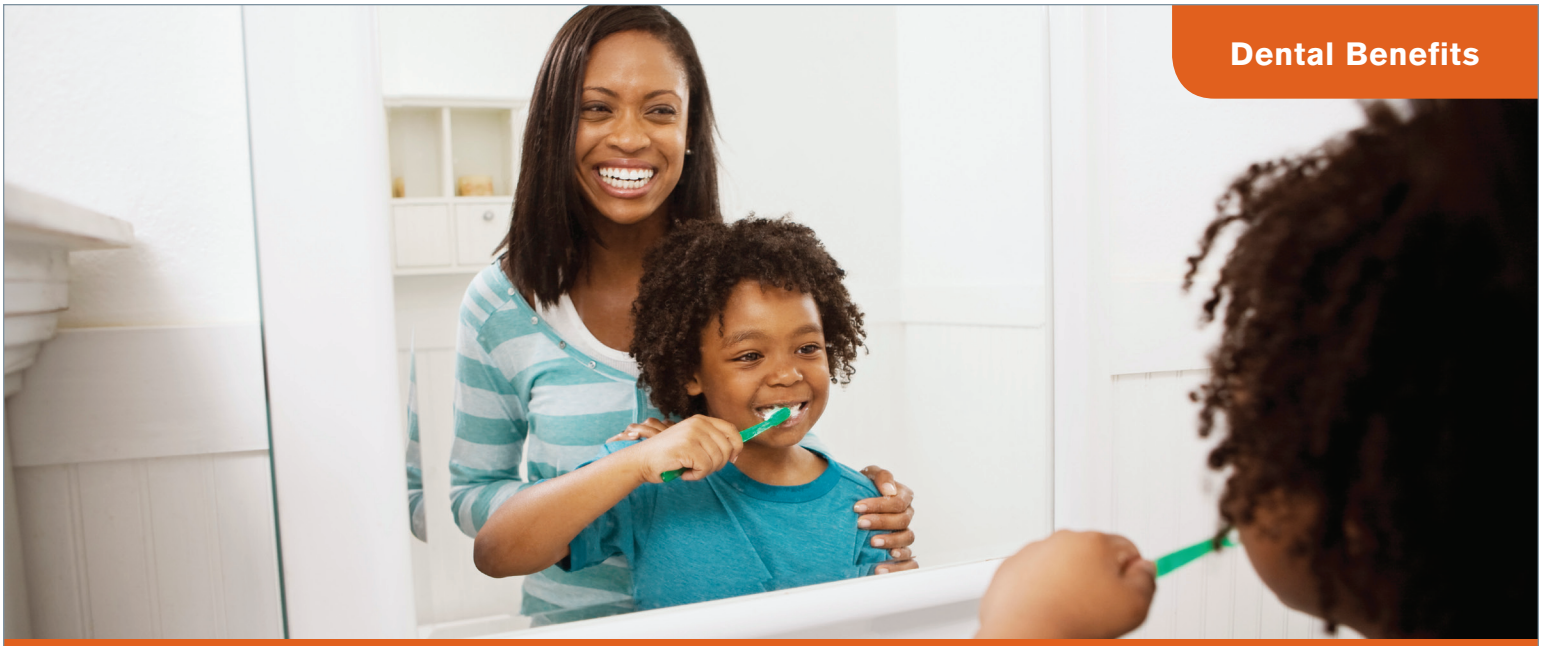
b) The charge for each additional month will not exceed $125.00 per month.

IV. SERVICES NOT PROVIDED

The following are not benefits included as part of orthodontic services provided by PACIFIC UNION DENTAL.

a) Start-up including:
   1. Cephalometric x-rays*
   2. Tracings*
   3. Study models*
   4. Photos*
b) Lost or broken appliances.
c) Retreatment of orthodontic cases.
d) Treatment in progress at inception of eligibility.
e) Changes in treatment necessitated by accident of any kind.
f) Extraction of teeth or surgical procedures performed for orthodontic purposes.
g) Replacement (including bridgework) or restoration (including crowns) of teeth caused solely by the orthodontic treatment.
h) Orthodontics for TMJ problems including assessment beyond that customarily provided in general practice.
i) Cases involving:
   1. Surgical orthodontics.
   2. Myofunctional therapy.
   3. Cleft palate.
   4. Micrognathia.
   5. Macroglossia.
   6. Hormonal imbalances.
   7. Phase I orthodontic care.
   8. Orthodontic care prior to age ten or after the age of nineteen.
j) Transfer of Orthodontic provider for any reason in the middle of treatment.
k) Orthodontic cases extending beyond the 19th birthday are subject to loss of benefit residual obligation provision (refer to SECTION II LOSS OF BENEFIT/RESIDUAL OBLIGATIONS).
l) Any treatment rendered by any noncontracted Orthodontic provider.

* Start-up fees subject to additional combined charge not to exceed $350.00.



Dental Benefits

Dental benefits at myuhcdental.com

Get the most out of your dental benefits. **myuhcdental.com** has practical tools and personalized information for your dental care. Register at **myuhcdental.com** and connect to view, learn about and manage your dental benefits.

Great reasons to use myuhcdental.com

1. Learn about dental health conditions, treatments and procedures.

Our dental health information is in plain English and gets right to the point. Learn about the latest techniques and view current news. You also have resources such as a dental terminology section, so you can understand the words used in your dental treatment plan.

▸ **Select** *Dental Education*

2. Compare costs for treatments: network and non-network.

View detailed benefit information, including limitations; explore various treatment costs; compare network and non-network costs for specific procedures; and know out-of-pocket expense prior to dental appointments.

▸ **Select** *Treatment Cost Calculator*

3. Locate and get information about dentists and specialists.

Locate the most convenient network dentist or specialist for you and your family. You can search for a dentist nearest your home or office, and find locations offering features such as wheelchair access or weekend office hours.

▸ **Select** *Dentist Locator*

4. Check your dental claims online.

Research dental claims by date, determine claim status, view and print claims details, as well as pretreatment estimates, all real-time and up-to-the-minute.

Register at myuhcdental.com today. It's simple – turn this page for instructions.

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5. Find answers to the most frequently asked questions.

Find out how to find a dentist, when you need to see a specialist, where to find assistance with your plan, how to make an appointment, what to do for a dental emergency, and much more.

- **Select** *Plan Information*

6. Learn more about your coverage.

Better utilize and understand your benefits by viewing plan details – check your current eligibility, copayments, deductibles and out-of-pocket costs.

- **Select** *Plan Information*

7. Request a dental ID card.

Request a replacement card anytime.

- **Select** *Plan Information*

7. A Site Tour shows you the way. Don't know where to start?

The Site Tour demonstrates how **myuhcdental.com** can help you maximize your understanding of the site, take full advantage of the tools and information, and become a more informed member.

- **Select** *Site Tour*

Note: If you have medical coverage through UnitedHealthcare: log in to **myuhc.com**® to automatically access both medical and dental benefit information.

Register now – here's how

1 Log on to **myuhcdental.com** and click 'Register Now'

2 Enter the requested information

3 Begin using the site

All about benefits

- Confirm plan eligibility
- View a personalized summary of dental benefit coverage

Find a dentist or specialist

- Nominate a dentist to join our dental network
- Compare treatment costs (network and non-network)
- Request a replacement (or an additional) dental ID card
- Find answers to frequently asked questions

If you have medical coverage through UnitedHealthcare: log in to **myuhc.com** to access both medical and dental benefit information.

Better information/ better health

- Access benefit plan information
- Check your claims status and history
- Review new dental techniques, studies, terminology, and information about good dental habits
- Know your out-of-pocket expenses using the Treatment Cost Calculator

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VSP
Vision care for life

Keep your eyes healthy with IBEW LOCAL 595 and VSP® Vision Care.

Why enroll in VSP? Your eyes deserve the best care to keep them healthy year after year. Plus with VSP, you'll get a great value on your eyecare and eyewear.

You'll like what you see with VSP.

- **Value and Savings.** You'll get great benefits on your exam and eyewear at an affordable price.
- **Personalized Care.** You'll get quality care that focuses on your eyes and overall wellness through a WellVision Exam® from a VSP doctor. When you see a VSP doctor, you'll get the most out of your benefit and have lower out-of-pocket costs. Plus, with a VSP doctor your satisfaction is guaranteed—if you're not 100% happy, we'll make it right.
- **Great Eyewear.** Choose the eyewear that's right for you and your budget.
- **Choice of Providers.** With open access to see any eyecare provider, you can see the one who's right for you. Choose a VSP doctor or any other provider.

Using your VSP benefit is easy.

- **Find an eyecare provider who's right for you.**
  To find a VSP doctor, visit **vsp.com** or call **800.877.7195**.
- **Review your benefit information.**
  Visit **vsp.com** to review your plan coverage before your appointment.
- **At your appointment, tell them you have VSP.**
  There's no ID card necessary.

That's it! We'll handle the rest—there are no claim forms to complete when you see a VSP doctor.

Choice in Eyewear

From classic styles to the latest designer frames, you'll find hundreds of options for you and your family. Choose from great brands, like bebe®, Calvin Klein, Disney, FENDI, Nike, and Tommy Bahama®.

Enroll in VSP today. You'll be glad you did.

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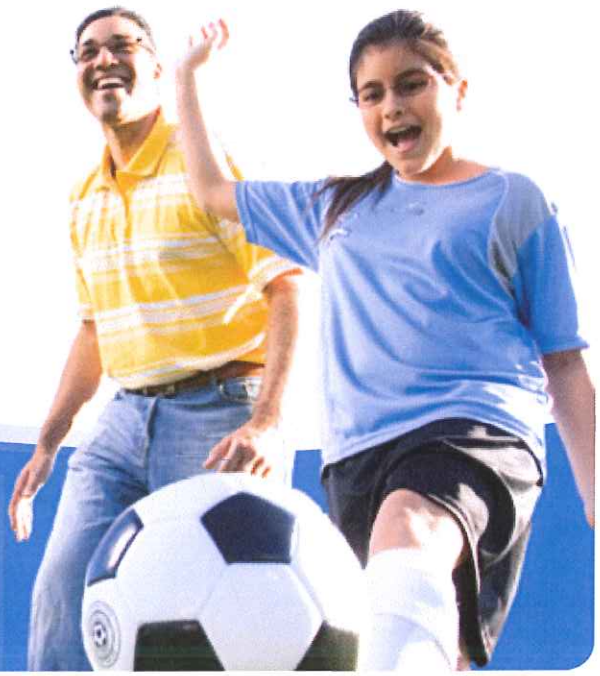

Your VSP Vision Benefits Summary

IBEW LOCAL 595 and VSP provide you with an affordable eyecare plan.

VSP Coverage Effective Date: 02/01/2013
VSP Doctor Network: VSP Choice

Visit **vsp.com** for more details on your vision benefit and for exclusive savings and promotions for VSP members.

Benefit	Description	Copay	Frequency
Your Coverage with a VSP Doctor			
WellVision Exam	• Focuses on your eyes and overall wellness	$20 for exam and glasses	Every 12 months
Prescription Glasses			
Frame	• $150 allowance for a wide selection of frames • 20% off amount over your allowance	Combined with exam	Every 24 months
Lenses	• Single vision, lined bifocal, and lined trifocal lenses • Polycarbonate lenses for dependent children	Combined with exam	Every 24 months
Lens Options	• Standard progressive lenses • Premium progressive lenses • Custom progressive lenses • Average 20-25% off other lens options	$55 $95 - $105 $150 - $175	Every 24 months
Contacts (instead of glasses)	• $130 allowance for contacts; copay does not apply • Contact lens exam (fitting and evaluation)	Up to $60	Every 24 months
Diabetic Eyecare Plus Program	• Services related to type 1 and type 2 diabetes; ask your VSP doctor for details	$20	As needed
ProTec Safety® (Employee-only coverage)			
Frame	• Fully covered when you choose a safety frame from your VSP doctor's ProTec Eyewear® collection • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	$20 for frame and lenses	Every 24 months
Lenses	• Prescription single vision, lined bifocal, and lined trifocal • Certified according to the American National Standards Institute (ANSI) guidelines for impact protection	Combined with Frame	Every 24 months
Extra Savings and Discounts	**Glasses and Sunglasses** • 20% off additional glasses and sunglasses, including lens options, from any VSP doctor 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 Other Providers

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

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

VSP guarantees coverage from VSP doctors only. Coverage information is subject to change. In the event of a conflict between this information and your organization's contract with VSP, the terms of the contract will prevail.

IBEW LOCAL 595 TRUST FUNDS

RE: DEPENDENT COVERAGE

Dear Participant:

The following information is necessary to add dependents to your healthcare coverage. Coverage for a Spouse and dependents can be provided for any Eligible Active Participant, upon full completion of your Enrollment Form which will be kept on file at the Benefit Office. Please see the below required documentation specific to your situation:

□ **Marriage Certificate**	If you are married, please send the Trust Fund Office a photocopy of your marriage certificate to your current Spouse. A copy of your marriage certificate must be included before coverage will be activated for your spouse.
□ **Declaration of Domestic Partner**	If you have a registered Domestic Partner, please submit a photocopy of your Declaration of Domestic Partnership.
□ **Proof of Dependency for Adopted Children**	Please provide the Plan proof of adoption: legal adoption documents or documents showing placement of your child(ren) with you for purposes of adoption.
□ **Additional Insurance**	Please provide any information regarding your Spouse's other insurance coverage through his/her employer, if applicable. We also must have any information regarding other insurance coverage for each dependent, if applicable
□ **Birth Certificates**	Please submit photocopies of birth certificates for: You, your spouse/Domestic Partner, and any Dependent Children you wish to enroll onto the Plan (including step children, and adopted children). A copy of each child's birth certificate is required, before coverage will be activated.

By providing the Benefit Office with any information in regards to other insurance coverage your Spouse and/or children may have in addition to the IBEW Local 595 Health & Welfare Plans, you are doing your part in controlling the escalating costs of your Health Plan Benefits.

Sincerely,

The Eligibility Department

7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566 • P O Box 3420 • San Ramon, CA 94583
Phone 925-208-9996 • Toll Free 888-512-5863 • Fax 925-362-8564
www.ibew595benefits.org • staff@ibew595benefits.org

IBEW LOCAL 595 TRUST FUNDS

BENEFICIARY FORM FOR HEALTH AND WELFARE PLAN

EMPLOYEE LAST NAME: _____ FIRST NAME: _____ MIDDLE NAME: _____

SOCIAL SECURITY NO: _____ DATE OF BIRTH: _____ PHONE NUMBER: _____

STREET ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

CURRENT MARITAL STATUS (PLEASE CHECK ONE): ☐ MARRIED ☐ NEVER MARRIED ☐ DIVORCED ☐ DIVORCED & REMARRIED ☐ WIDOW(ER)

SPOUSE'S NAME (IF LEGALLY MARRIED): _____ DATE OF MARRIAGE: _____

SPOUSE'S SOCIAL SECURITY NO: _____ IF DIVORCED OR SEPARATED, GIVE DATE: _____

LIST FIRST NAMES AND DATES OF BIRTH FOR ALL DEPENDENT CHILDREN: _____

LIST ANY OTHER DEPENDENTS AND RELATIONSHIPS: _____

EXPLANATION REGARDING DESIGNATION OF BENEFICIARY

You may designate any individual or individuals as your beneficiary. Also, you may designate the same person to receive all types of benefits named on the lower portion of this form, or different persons to receive each of them. If you list more than one beneficiary, they shall share equally in the applicable benefits. You also may designate a contingent beneficiary to receive benefits if your primary beneficiary(ies) should die. If you do not designate anybody, then applicable benefits will be payable as provided under the Plan.

BE SURE TO COMPLETE THE ENTIRE FORM AND RETURN TO THE TRUST OFFICE.

BENEFICIARY DESIGNATION

I, _____, Social Security No. _____ do hereby designate the following named person or persons as my beneficiary or beneficiaries to receive any monies that may be payable by reason of my death, under the IBEW Local 595 Health and Welfare Plan. Pay any life insurance and accidental death and dismemberment benefits, if applicable to:

PRINT NAME OF BENEFICIARY: _____ SOCIAL SECURITY NO. _____ RELATIONSHIP: _____

ADDRESS: _____ DATE OF BIRTH: _____

PRINT NAME OF BENEFICIARY: _____ SOCIAL SECURITY NO. _____ RELATIONSHIP: _____

ADDRESS: _____ DATE OF BIRTH: _____

CONTINGENT BENEFICIARY: _____ SOCIAL SECURITY NO. _____ RELATIONSHIP: _____

Date _____ **Signature:** _____

THE INFORMATION REQUESTED ON THIS CARD MUST BE COMPLETE AND BE ON FILE WITH THE FUND'S ADMINISTRATOR PRIOR TO YOUR DEATH OR INJURY

IBEW LOCAL 595 TRUST FUNDS

IBEW LOCAL 595 HEALTH & WELFARE PLAN
AUTHORIZATION TO DEDUCT "BUY UP" AMOUNT FROM HRA ACCOUNT

Member Name: _____

Social Security #: _____

Address: _____

_____

My signature below is authorization to have the monthly Buy Up amount ($279.50) currently required for continued enrollment in UnitedHealthcare HMO or the Blue Cross PPO (Self-Funded Indemnity Plan) deducted from my Health Reimbursement Account (HRA). I understand that the Buy Up amount may change in the future and that this authorization will also apply to any such changed amount. I understand that this monthly deduction from my HRA will continue under the terms of the IBEW Local 595 Health & Welfare Plan rules.

PLEASE BE ADVISED THAT IF YOU CHOOSE TO USE YOUR HRA TO MAKE YOUR PAYMENT, YOU WILL BE CHARGED THE FULL BUY UP AMOUNT (CURRENTLY $279.50). IF YOUR HRA ACCOUNT FALLS BELOW THE BUY UPAMOUNT YOU WILL BE BILLED FOR THE ENTIRE AMOUNT.

****** PLEASE NOTE THAT IF YOU ARE BILLED FOR THE BUY UP AND YOU DO NOT PAY BY THE DUE DATE, YOUR COVERAGE WILL TERMINATE FOR YOUR CURRENT HEALTH COVERAGE AND YOU WILL BE PLACED IN THE PLAN'S DEFAULT OPTION. ******

This authorization will remain in effect until you submit a written statement to the Trust Fund Office rescinding this authorization.

_____ _____

Member's Signature Date

_____

Member's SS#

Please return this form to: IBEW Local 595 Health & Welfare Plan
P.O. Box 3420
San Ramon, Ca 94583

Instructions for completing the

Authorization for Release of Protected Health Information

There is a section for the Member/Retiree, Spouse and if applicable, a section for a dependent child(ren) over the age of 18.

Member Section /Retiree Section

1. Fill in your name and social security number.
2. **If you are married** and you want to give your spouse authority to inquire about your health information, please enter his/her name and relationship (spouse) –or-
   If you are not married or **you want to give someone other than your spouse** authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.).
3. **If you are giving someone else authority, please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself". **Please sign and date below the box**.

Spouse Section

1. Fill in your name and social security number.
2. **If you want to give your spouse (member/retiree)** authority to inquire about your health information, please enter his/her name and relationship (spouse).
   If you want to give someone other than your spouse authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.), **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box**.

Dependent(s) over the age of 18 Section

1. Fill in your name and social security number.
2. **If you want to give your parents** authority to inquire about your health information, please enter their name and relationship (father, mother).
   If want to give someone other than your parents authority to inquire about your health information, please enter his/her name and relationship (mother, father, friend, etc.) **please sign and date form.**

   OR

   If you do not want to give anyone other than yourself authority to inquire about your health information, then place an "X" in the box where it says "I do not want my Health Information released to anyone but myself".
3. **Please sign and date form below the box**.

Authorization for Release of Protected Health Information

MEMBER/RETIREE SECTION

I, (print your name and Social Security number) _____ **authorize the Health and Welfare Plan (the "Plan"), and its business associates, to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired), at the request of such persons:**

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I understand that this authorization will expire upon termination of my enrollment in the Plan, unless I revoke it sooner. I understand that I have the right to revoke it at any time, except to the extent that it has already been relied upon. I understand that if I decide to revoke this authorization, I must give notice of my decision in writing and send it to:

IBEW Local 595 Health & Welfare Plan
P O Box 3420 • San Ramon, CA 94583
Phone 925-208-9996 • Toll Free 888-512-5863 • Fax 925-362-8564
www.ibew595benefits.org • staff@ibew595benefits.org

I understand that my health information that is disclosed pursuant to this authorization may be re-disclosed by the persons I have identified above, and the Plan cannot prevent or protect such re-disclosures, AND I understand that I am not required to sign this form to receive my health care benefits (enrollment, treatment or payment).

Signature of Member_____**Date Signed:** _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Member_____**Date Signed**: _____

SPOUSE SECTION

I, the **spouse** (**Name, Please Print**) _____, (**Spouse's Social Security #**) _____of the above named member, have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Spouse_____ **Date Signed**: _____

-OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Spouse_____ **Date Signed**: _____

DEPENDENT(S) OVER THE AGE OF 18 SECTION

I, the **dependent child(ren)** over the age of 18 (**Name, Please Print)**_____,**(Social Security #)** _____have also read, understand, and authorize the Plan to disclose claims, payment, eligibility and other related health information about me to the following persons (select 1-2 persons if desired) for the reasons and with the explanations listed above, except at the request of such persons:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Signature of Dependent_____**Date Signed**: _____

OR- ☐ I do not want my Health Information released to anyone but myself.

Signature of Dependent_____**Date Signed**: _____

NOTE: If there is more than one dependent over the age of 18, please copy, complete and sign the appropriate number of additional Authorization Forms and return to the Benefit Office.

IBEW LOCAL 595 TRUST FUNDS

NOTICE OF THE PRIVACY PRACTICES OF THE IBEW LOCAL 595 HEALTH & WELFARE PLAN

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.

We are required by law, namely the federal Health Insurance Portability and Accountability Act of 1996 (HIPAA), to make sure that medical information that identifies you is kept private to the extent required by law. We are also required to give you this notice regarding (1) the uses and disclosures of medical information that may be made by the Plan, and (2) your rights and the Plan's legal duties with respect to such information. This notice and its contents are intended to conform to the requirements of HIPAA.

How We May Use and Disclose Medical Information About You

The following categories describe different ways that we use and disclose medical information. Not every use or disclosure in a category will be listed. However, all of the ways we are permitted to use and disclose information will fall within one of the categories.

Treatment. Treatment is the provision, coordination or management of health care and related services. It also includes but is not limited to consultations and referrals between one or more of your providers. For example, we may disclose to a treating orthodontist the name of your treating dentist so that the orthodontist may ask for your dental x-rays from the treating dentist.

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. For example, we may tell your health care provider about your eligibility for benefits to confirm whether payment will be made for a particular service. We may also share medical information with a utilization review or precertification service provider. Likewise, we may share medical information with another entity to assist with the coordination of benefit payments.

For Health Care Operations. We may use and disclose medical information about you for Plan operations. These uses and disclosures are necessary to run the Plan. For example, we may use medical information in connection with conducting quality assessment and improvement activities; underwriting, premium rating, and other activities relating to Plan coverage; reviewing and responding to appeals; conducting or arranging for medical review, legal services, audit services, and fraud and abuse detection programs; and general Plan administrative activities.

As Required By Law. We will disclose medical information about you when required to do so by federal, state or local law. For example, we may disclose medical information when required by a court order in a litigation proceeding such as a malpractice action. When authorized by law to report information about abuse, neglect or domestic violence to public authorities, we may disclose medical information if there exists a reasonable belief that you may be a victim of abuse, neglect or domestic violence. In such a case, the Plan will promptly inform you that such a disclosure has been or will be made unless that notice would cause a risk of serious harm. For the purpose of reporting child abuse or neglect, it is not necessary to inform the minor that such a disclosure has been or will be made. Disclosure may generally be made to the minor's parents or other representatives although there may be circumstances under federal or state law when the parents or other representatives may not be given access to the minor's health information.

To Avert a Serious Threat to Health or Safety. We may use and disclose medical information about you when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

To Inform You About Treatment Alternatives or Other Health Related Benefits. We 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. For instance, we may forward a communication to a participant who is a smoker regarding an effective smoking-cessation program.

Disclosure to Health Plan Sponsor. Medical information may be disclosed to the Plan Sponsors, i.e. the Union and the Associations, or Plan Trustees, solely for purposes of administering benefits under the Plan.

Organ and Tissue Donation. If you are an organ donor, we may release medical information to organizations that handle organ procurement or transplantation.

Military and Veterans. If you are a member of the armed forces, we may release medical information about you as required by military command authorities.

Workers' Compensation. We may release medical information about you for workers' compensation or similar programs.

Public Health Risks. We may disclose medical information about you for public health activities to a public authority. These disclosures will be made for the purpose of controlling disease, injury or disability.

Health Oversight Activities. We may disclose medical information to a health oversight agency for activities authorized by law, such as audits, investigations, inspections, and licensure.

Lawsuits and Disputes. We may disclose medical information in response to a court order or administrative tribunal. We may also disclose medical information in response to a subpoena, discovery request, or other lawful process, that is not accompanied by an order of a court or administrative tribunal, if we receive satisfactory assurance from the party seeking the information that reasonable efforts have been made to notify you of the request or, if such assurance is not forthcoming, if we have made a reasonable effort to notify you about the request.

Law Enforcement. We may release medical information if asked to do so for law enforcement purposes so long as applicable legal requirements have been met.

Coroners, Medical Examiners and Funeral Directors. We may release medical information to a coroner or medical examiner.

Research. We may disclose medical information for research, subject to conditions.

National Security and Intelligence Activities. We may release medical information about you to authorized federal officials for intelligence, counterintelligence, and other national security activities authorized by law.

Inmates. If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release medical information about you to the correctional institution or law enforcement official.

Your Rights Regarding Medical Information About You

You have the following rights regarding medical information we maintain about you:

Right to Inspect and Copy. 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. 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. 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.

Right to Amend. If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment 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, other than disclosures made (1) to carry out treatment, payment or health care operations, (2) to individuals about their own medical information, (3) incident to an otherwise permitted use or disclosure, (4) pursuant to an authorization, (5) for purposes of creation of a facility directory or to persons involved in the patient's care or other notification purposes, (6) as part of a limited data set, (7) for other national security or to correctional institutions or law enforcement officials, or (8) before April 14, 2003.

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 shall accommodate such a request if the participant clearly provides information that the disclosure of all or part of that information could endanger the participant. 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.

Changes to This Notice

The effective date of this Notice is April 14, 2003. We reserve the right to (1) change this notice, and (2) to make the revised or changed notice effective for medical information we already have about you as well as any information we receive in the future. If any changes are made, we will mail the revised Notice to participants. The Plan will comply with the terms of any such Notice currently in effect.

Complaints/Requests for Information

If you believe your privacy rights have been violated, you may file a complaint with the Plan or with the Secretary of the Department of Health and Human Services. To file a complaint with the Plan, or to receive further information as required by the regulations, contact Renay Deeby at the Plan Office. All complaints must be submitted in writing. You will not be penalized for filing a complaint.

Other Uses of Medical Information

Other uses and disclosures of medical information not covered by this notice or the laws that apply to us will be made only with your written permission. If you provide us permission to use or disclose medical 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 medical 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.

HOW TO READ YOUR MONTHLY BENEFIT STATEMENT

I.B.E.W. LOCAL 595
TRUST FUNDS
MONTHLY BENEFIT STATEMENT

❶

SAMUEL SAMPLE
Participant ID: 0123456789
August 2010

Health and Welfare Status

❷ You are eligible for coverage for AUGUST 2010 through OCTOBER 2010.

	2,118.12	Previous Dollar Bank Balance (including contributions reported late)
+	2,398.00	Credited Amount for June 2010 work month
-	1,417.00	Amount used to maintain eligibility for August 2010
	3,099.12	Current Dollar Bank Balance

❸ You are currently enrolled in: Blue Cross Indemnity Plan, Delta Dental, Prescription Solutions Rx, Family

❹

Currently Enrolled:

SAMUEL SAMPLE	07/23/1969
STEPHANIE SAMPLE	11/04/1971
SYDNEY SAMPLE	08/24/2000

Credited Contributions Received on Your Behalf

❻

❺

EMPLOYER	WORK MONTH	DATE RECEIVED	HOURS WORKED	HEALTH CARE AMOUNT	* DEFINED BENEFIT AMOUNT	MONEY PURCHASE AMOUNT	VACATION / DUES AMOUNT	HRA AMOUNT
BALANCE FORWARD							715.35	
ABC ELECTRIC	06/01/2010	07/01/2010	220.00	2,398.00	990.36	721.60	646.96	220.00
TOTAL			220.00	$2,398.00	$990.36	$721.60	$1,362.31	$220.00

** The amount listed in the Defined Benefit column above is only the accruing portion of your benefit.*

❶ Name of Participant, Participant ID (assigned by the Trust Fund Office), and the date of the Monthly Benefit Statement.

❷ Month(s) you are eligible for coverage.

❸ Participant current coverage enrollment.

❹ This area lists those enrolled under your coverage and their birth dates. Contact the Trust Fund Office if any information is incorrect or missing. It is important to keep this information accurate to avoid breaks in coverage.

❺ Your employer and the hours that were reported are listed here. Expect a **two month delay** between when you work and when the hours appear on the Benefit Statement. For example, work you perform in June is reported in July and should be on your August Benefit Statement. Contact the Trust Fund Office if you worked for an employer that is not listed or the information is incorrect.

❻ For work performed in the West, this amount represents your net vacation amount. For work performed in the East, this amount represents your working dues amount.

Please look on the reverse side of the Monthly Benefit Statement for notices and other important information.

STAFF@IBEW595BENEFITS.ORG

Notice of COBRA Continuation Coverage Rights

Introduction

You are receiving this notice because you have recently become covered under the IBEW Local 595 Health and Welfare Fund ("The Fund"). This notice contains important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under the Plan. The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and to other members of your family who are covered under the Plan when you would otherwise lose your group health coverage. This notice generally explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect the right to receive it. This notice gives only a summary of your COBRA continuation coverage rights. For more information about your rights and obligations under the Plan and under federal law, you should either review the Plan's Summary Plan Description or get a copy of the Plan Document from the Fund Office.

The Plan administrator is BeneSys Administrators (the "Fund Office") located at P.O. Box 3420, San Ramon, CA 94583. You can call the office at 925-208-9996 or 888-512-5863. The Plan administrator is responsible for administering COBRA continuation coverage.

COBRA Continuation Coverage

COBRA continuation coverage is a continuation of Plan coverage when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later in this notice. COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." A qualified beneficiary is someone who will lose coverage under the Plan because of a qualifying event. Depending on the type of qualifying event, employees, spouses of employees, and dependent children of employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you are an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because either one of the following qualifying events happens:

1. Your hours of employment are reduced, or
2. Your employment ends for any reason other than your gross misconduct.

If you are the spouse of an employee, you will become a qualified beneficiary if you will lose your coverage under the Plan because any of the following qualifying events happens:

1. Your spouse dies;
2. Your spouse's hours of employment are reduced;
3. Your spouse's employment ends for any reason other than his or her gross misconduct;
4. Your spouse becomes enrolled in Medicare (Part A, Part B or both); or
5. You become divorced or legally separated from your spouse.

Your dependent children will become qualified beneficiaries if they will lose coverage under the Plan because any of the following qualifying events happens:

1. The parent-employee dies;
2. The parent-employee's hours of employment are reduced;
3. The parent-employee's employment ends for any reason other than his or her gross misconduct;
4. The parent-employee becomes enrolled in Medicare (Part A, Part B, or both);
5. The parents become divorced or legally separated; or
6. The child stops being eligible for coverage under the plan as a "dependent child."

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Plan Administrator has been notified that a qualifying event has occurred. When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the Plan Administrator of the qualifying event within 30 days of any of these events.

For other qualifying events (divorce or legal separation of the employee and spouse or a dependent child's losing eligibility for coverage as a dependent child), you must notify the Plan Administrator. The Plan requires you to notify the Plan Administrator within 60 days after the qualifying event occurs. You may send written notice of the event to: IBEW Local 595 Health and Welfare Fund, P.O. Box 3420, San Ramon, CA 94583, or you can report a qualifying event by calling the Fund Office at 925-208-9996 or 888-512-5863 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation to the Fund Office at: P.O. Box 3420, San Ramon, CA 94583.

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date of the qualifying event.

COBRA continuation coverage is a temporary continuation of coverage. When the qualifying event is the death of the employee, enrollment of the employee in Medicare (Part A, Part B, or both) your divorce or legal separation, or dependent child losing eligibility as a dependent child, COBRA continuation coverage lasts for up to 36 months.

When the qualifying event is the end of employment or reduction of the employee's hours of employment, COBRA continuation coverage last for up to 18 months. There are two ways in which this 18-month period of COBRA continuation coverage can be extended.

Disability Extension Of 18-Month Period Of Continuation Coverage

If you or anyone in your family covered under the plan is determined by the Social Security Administration to be disabled at any time during the first 60 days of COBRA continuation coverage and you notify the Plan Administrator in a timely fashion, you and your entire family can receive up to an additional 11 months of COBRA continuation coverage, for a total maximum of 29 months. You must make sure that the Plan Administrator is notified of the Social Security Administration's determination within 60 days of the date of the determination and before the end of the 18-month period of COBRA continuation coverage. This notice should be sent along with a copy of the Social Security Administration's determination to the IBEW Local 595 Health and Welfare Fund, P.O. Box 3420, San Ramon, CA 94583.

Second Qualifying Event Extension of 18-month Period of Continuation Coverage

If your family experiences another qualifying event while receiving COBRA continuation coverage, the spouse and dependent children in your family can get additional months of COBRA continuation coverage, up to a maximum of 36 months. This extension is available to the spouse and dependent children if the former employee dies, enrolls in Medicare (Part A, Part B, or both), or gets divorced or legally separated. The extension is also available to a dependent child when that child stops being eligible under the Plan as a dependent child. In all of these cases, you must make sure that the Plan Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to: IBEW Local 595 Health and Welfare Fund, P.O. Box 3420, San Ramon, CA 94583, or you can report a qualifying event by calling the Fund Office at 925-208-9996 or 888-512-5863 and speaking to a representative in the eligibility department. You will be required to send a full copy of your divorce decree or documentation of your legal separation, or Medicare Card to the Fund Office at: P.O. Box 3420, San Ramon, CA 94583.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact the Fund Office by calling 925-208-9996, or 888-512-5863. Written correspondence should

be sent to: IBEW Local 595 Health and Welfare Fund, P.O. Box 3420, San Ramon, CA 94583. You may also contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA). Addresses and phone numbers of Regional and District EBSA offices are available through EBSA's website at **www.dol.gov/ebsa**.

Keep Your Plan Informed of Address Changes

In order to protect your family's rights, you should keep the Plan Administrator informed of any changes in the addresses of family members. You should also keep a copy, for your records, of any notices you send to the Plan Administrator.

IBEW LOCAL 595 TRUST FUNDS

ENROLLMENT FORM

CHECK ALL THAT APPLY: □ **New Enrollment** □ **Adding Dependents** □ **Plan Change** □ **Address Change**

EMPLOYEE'S FULL NAME: _____ SSN: _____

ADDRESS: _____ CITY: _____

STATE: _____ ZIP: _____ DATE OF BIRTH: _____

PHONE NUMBER: (_____) _____ SEX: MALE _____ FEMALE _____

ACTIVE/NON MEDICARE RETIREES MEDICAL PLAN
(CHOOSE ONE): * Actives subject to $279.50 Monthly Buy-up for non-Base Medical Plan.

☐ **INDEMNITY PLAN with Blue Cross PPO, Dental & Vision ***

☐ **ADDITIONAL DEDUCTIBLE INDEMNITY PLAN with Blue Cross PPO without Dental or Vision** (Deductible is $3574 for Individuals & $3774 for the Family)

☐ **UNITED HEALTH CARE HMO** *

☐ **KAISER** (Base Medical Plan)

DENTAL: (CHOOSE ONE) Not available with ADDITIONAL Deductible Indemnity Plan Option

☐ **DELTA DENTAL**

☐ **UNITED HEALTH CARE DENTAL**

MEDICARE RETIREE + DEPENDENTS
(CHOOSE ONE):

☐ **UHC MEDICARE ADVANTAGE NATIONAL PPO**
(dependents) UNITED HEALTH HMO

☐ **KAISER - SENIOR ADVANTAGE**
(dependents) KAISER

VISION:

Vision care for Active/Non-Medicare Retirees is provided through Vision Service Plan (VSP)

Vision Care for Medicare Retirees is provided through the Carrier.

Medicare Claim Number including the letter(s) that follows the number
(Only applies when member, spouse, or a covered dependent is age 65 or older or on Medicare disability – Please include copy of card)

Member #: _____ Spouse #: _____ Dependent Name/#: _____

DEPENDENTS - (Including Spouse) Include additional dependents on separate page

FULL NAME	RELATIONSHIP	BIRTH DATE	SOCIAL SECURITY NUMBER
_____	_____	_____	_____
_____	_____	_____	_____

I agree to notify the Fund Office within 30 days of any changes to the above information. Further, I declare all the above information to be complete and correct. I understand that stating false or misleading information or the omission of material information could be grounds for denial of benefits.

DATE: _____ MEMBER SIGNATURE _____

7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566 • P O Box 3420, San Ramon, CA 94583
Phone 925-208-9996 • Toll Free 888-512-5863 • Fax 925-362-8564
www.ibew595benefits.org • staff@ibew595benefits.org

OTHER INSURANCE INQUIRY

Please complete and return this form, if you, your spouse, or any of your dependents have other insurance coverage, or if there has been any change in other insurance coverage.

**** Please include a copy of the FRONT AND BACK of each card (Medical, Dental, Vision) ***

INCOMPLETE DOCUMENTATION WILL RESULT IN POSSIBLE DELAYS IN CLAIMS PROCESSING

General Information:

Member's Name: _____ SSN or ID#: _____

Name of Other Insured Person (Policy Holder): _____

Other Policy Holder's Date of Birth: _____

Relationship to Member: _____

Information about Other Insurance Plan or Program:

Does this plan include **Medical** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Medical Carrier: _____ Phone #: _____

Address: _____

Effective Date: _____Termination Date (if applicable): _____ Policy/Group Number: _____

Does this plan include **Dental** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Dental Carrier: _____ Phone #: _____

Address: _____

Effective Date:_____ Termination Date (if applicable): _____ Policy/Group Number:_____

Does this plan include **Vision** coverage? YES NO If yes, is this plan an: HMO or PPO

Name of Vision Carrier:_____Phone #: _____

Address:_____

Effective Date: _____Termination Date (if applicable): _____ Policy/Group Number: _____

If other coverage is for a child, please circle one regarding you and the other parent:

Married Divorced Domestic Partner (boyfriend/girlfriend)

- **If divorced or separated from other parent, please include a full copy of your Dissolution of Marriage Judgment or other child custody documents.**

Coverage is (circle): Single Family

List **ALL** Covered Dependents including Spouse if applicable.

1._____ 2. _____

Member Statement:

The above information is true and accurate to the best of my knowledge and belief. I also am aware of the fact that I must notify the Fund Office immediately should any of the dependents listed on my coverage become eligible for any other coverage.

Any materials submitted by myself or on behalf of any eligible person that contains a material alteration or forged or false information, including signatures, will be rejected. The Trustees reserve the right to refer such matters to Fund Legal Counsel for appropriate action. This will not limit the right of the Fund to recover any losses it suffers as a result of such material in any matter.

_____ _____

Member/Dependent Signature **Date**

California Region Group Enrollment/Change Form

Please print or type in black ink only. See instructions on reverse before completing this form. Make a copy for your records.

TO BE COMPLETED BY EMPLOYER

Company name | Hire date (mm/dd/yyyy)

Group number | Enrollment unit | Effective enrollment/ change date (mm/dd/yyyy)

A. ENROLLMENT/CHANGE REASON *(see Change Table for assistance)* New group: ❑ Yes ❑ No

❑ New Hire *(complete sections A, B, C, D)* ❑ Open Enrollment *(complete sections A, B, C, D)*

Health Plan *(Check one)* ❑ HMO Plan ❑ Deductible Plan ❑ Other _____

❑ Loss of Other Coverage *(complete sections A, B, C, D)* ❑ Other *(please specify)* _____

❑ Name change *(complete sections A, B, C, D)* From: _____ To: _____

Event Date (mm/dd/yyyy) _____

B. EMPLOYEE Have you ever been a Kaiser Permanente member? ❑ Yes ❑ No

Medical Record No. *(if known)* | Social Security No.

Name (Last, First, MI) | Birth Date (mm/dd/yyyy) | Gender ❑ M ❑ F

Home Address | City | State | ZIP

Work Phone | Home Phone | E-mail

Ethnicity | Preferred Language

C. FAMILY For additional dependents, attach a separate sheet with employee's name at top. (Last, First, MI)

❑ Add ❑ Delete ❑ Spouse ❑ Domestic partner Gender ❑ M ❑ F	Social Security No.
Spouse/domestic partner name:	Birth Date (mm/dd/yyyy)
Former last name *(if any)*:	Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F	Social Security No.
Dependent name:	Birth Date (mm/dd/yyyy)
Relationship:	Medical Record No.
❑ Add ❑ Delete ❑ Child ❑ Student Gender ❑ M ❑ F	Social Security No.
Dependent name:	Birth Date (mm/dd/yyyy)
Relationship:	Medical Record No.

Do any of dependents above live at another address? ❑ Yes ❑ No If yes, complete the following:
Name (Last, First, MI): Address:

D. Kaiser Foundation Health Plan, Inc., and Kaiser Permanente Insurance Company Arbitration Agreement* :
I understand that (except for Small Claims Court cases, claims subject to a Medicare appeals procedure, and, if I am enrolled in coverage that is subject to the ERISA claims procedure regulation (29 CFR 2560.503-1), certain benefit-related disputes*) any dispute between myself, my heirs, relatives, or other associated parties on the one hand and Kaiser Foundation Health Plan, Inc. (KFHP), Kaiser Permanente Insurance Company (KPIC), any contracted health care providers, administrators, or other associated parties on the other hand, for alleged violation of any duty arising out of or related to membership in KFHP or coverage by KPIC, including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of legal theory, must be decided by binding arbitration under California law and not by lawsuit or resort to court process, except as applicable law provides for judicial review of arbitration proceedings. I agree to give up our right to a jury trial and accept the use of binding arbitration. I understand that the full arbitration provision is contained in the *Evidence of Coverage* and in the *Certificate of Insurance*.

** Disputes arising from any of the following KPIC products are not subject to binding arbitration: 1) Tiers 2 & 3 of the Point of Service (POS) Plans; 2), the Preferred Provider Organization (PPO) and Out of Area Indemnity (OOA) Plans; and 3), the KPIC dental plans.*

Employee/Applicant signature	Date	Employer signature	Date

0106-0040-04-r03
Revision date 05/2011

KAISER PERMANENTE®

California Region Group Enrollment/Change Form

General instructions

1. Please print firmly and legibly in black ink.
2. To enroll, the subscriber must reside or work within one of the ZIP codes listed on the enclosed sheet.
3. The employer must complete the first section titled "To be completed by employer."
4. The employer is responsible for confirming all information prior to submitting, especially effective dates, as these affect your Health Plan dues.
5. The employee/subscriber must complete Sections A and B. See right column for detailed instructions.
6. Be sure to sign and date the bottom of the form.
7. Once the form is complete (including employer section), the subscriber should make a copy for his or her records, and to use as a temporary ID card, after the effective date.
8. All changes to accounts, including effective dates and child or student status, will be made in accordance with the contractual agreement between the purchaser and Kaiser Permanente.

Instructions for completing employer and new enrollment sections and sections A through D:

To be completed by employer: The employer must complete all fields to ensure we have correct account and enrollment information.

Section A: The subscriber must complete this section.

Section B: The subscriber must always complete this section. Use the Change Table (below) for assistance.

Section C: The subscriber must indicate the requested change to the account and complete all fields for any dependents being enrolled. We will verify the eligibility of these dependents during the enrollment process. Be sure to include any former last names for both spouses and dependents. Also indicate the appropriate role. The student role should be marked only if the dependent qualifies as an "overage dependent" attending school. Please contact your employer regarding rules for overage dependent students. A completed *Student Certification* form may be required.

Section D: The subscriber must sign and date this section.

Change Table

Add dependent	**Event date**
Acquired student status*	Student status date
Family adoption*	Adoption date
Loss of coverage	Coverage loss date
New spouse (marriage)	Marriage date
Moved into service area	Move date
Newborn addition	Birth date
Open enrollment	Open enrollment effective date

Delete dependent	**Event date**
Loss of student status	Status change date
Divorce	Divorce date
Member deceased*	Death date
Delete dependent(s)	Dependent termination date
Open enrollment	Open enrollment effective date

Demographic Change	**Event date**
Address change, telephone number change	Status change date
Demographic (name, birthdate, social security number) change	Status change date

*Additional documentation may be required.

KAISER PERMANENTE®

0106-0040-04-r03
Revision date 05/2011

UnitedHealthcare®
PacifiCare®

Enrollment Form

Instructions

Section 1: Personal Information
Please complete information requested.

Section 2: Selected Coverage
- Select only the plans offered by your Employer.
- For each plan your Employer offers, select the individual to be covered.

Section 3: Employee & Dependent Information
- List yourself and family members to be covered. You may attach additional sheets if necessary.
- Social Security Number is a required field for you and each of your family members.
- Select a Primary Care Physician (PCP) from the *Provider Directory* for you and each of your family members by writing the PCP name and Provider number in the area provided. You may choose a different PCP for each member in your family.

  PCP selection is only required if a PacifiCare SignatureValue® (HMO) or PacifiCare SignaturePOS® plan is selected. If you do not select a PCP when selecting one of these plans, a PCP will be automatically assigned to you.
- Verify that domestic partner coverage is available through your Employer.
- Over-age Dependents require proof of full-time student status or permanent disability status within 31 days of enrollment.

Section 4: Benefit Coordination/Other Insurance Carrier Information
Please complete information requested, if applicable.

Employee Signature

You can either:
Accept the health care services coverage provided through your Employer by signing the space provided on the enrollment form. Your signature indicates that you have read, understand and agree to the terms and conditions below. Affixing your signature also indicates your acceptance of payroll deductions (if necessary) to pay your share of the cost.

OR

You can waive the health care services coverage provided through your Employer for yourself, your spouse or your Dependents by signing the DECLINATION OF COVERAGE FORM. We strongly recommend that you read through the entire form carefully before signing your name in ink and dating it. Please request the Declination of Coverage Form from your Employer.

Terms and Conditions – Please read carefully before signing

On behalf of myself and my eligible Dependents, I hereby apply for health care services coverage indicated in PacifiCare's Group Health Plan offered through my Employer, and agree to and understand the following:

1. To be bound by the PacifiCare Medical and Hospital Group Subscriber Agreement ("Agreement") if I have chosen the PacifiCare SignatureValue® (HMO), PacifiCare SignatureValue - HealthCare Partners Network (HMO), PacifiCare SignatureValue® Advantage, PacifiCare SignatureValue Advantage - Plan Bien℠ (HMO), PacifiCare SignaturePOS®, PacifiCare SignatureElite℠ (PPO), PacifiCare SignatureFreedom® (SDHP) or PacifiCare SignatureIndependence® (Indemnity) plan.
2. My Employer may deduct from my earnings the employee contribution required to cover my share of the premium, if any.
3. PacifiCare or a designee may access and/or use my medical records and the medical records of my enrolled Dependents, including mental health medical records and medical records from drug and alcohol abuse treatment or prevention, for purposes of Utilization Review, Quality Assurance, Surveys, Processing of Claims, Financial Audit or other purposes reasonably related to the performance of treatment, payment, or health care operations of the Agreement or Policy.

4. Any material omission or misrepresentation in answering the questions on this application may result in the denial of benefits and the termination of my and/or my Dependents' membership in the insurance policy with PacifiCare.
5. Coverage shall not begin until acceptance of this enrollment by PacifiCare. Upon acceptance of this application, PacifiCare shall be bound by the terms of the Agreement or Policy, and any Amendments thereto.
6. I have received, read and understand the PacifiCare Disclosure Form, Directory of Participating Medical Groups and a copy of this Enrollment Form.
7. My Dependents and I must reside in California and live or work in PacifiCare's service area if enrolling in the PacifiCare SignatureValue or PacifiCare SignaturePOS plan.
8. If my Dependents or I elect PacifiCare SignatureValue or PacifiCare SignaturePOS, we will select a Primary Care Physician within a 30-mile radius of our Primary Residence or Primary Workplace.

Detach here

PacifiCare SignatureValue (HMO) and PacifiCare SignatureValue Advantage (HMO Value Network)
P.O. Box 30981
Salt Lake City, UT 84130
1-800-624-8822
1-800-442-8833 (TDHI)
1-866-372-1316 (Fax)

PacifiCare SignaturePOS
P.O. Box 30981
Salt Lake City, UT 84130
1-800-913-9133
1-800-442-8833 (TDHI)
1-866-372-1316 (Fax)

PacifiCare SignatureElite (PPO) and PacifiCare SignatureIndependence (Indemnity)
P.O. Box 30981
Salt Lake City, UT 84130
1-866-316-9776
1-866-816-2018 (TDHI)
1-866-372-1316 (Fax)

PacifiCare SignatureFreedom (SDHP)
PacifiCare Health Plan Administrators, Inc.
P.O. Box 30981
Salt Lake City, UT 84130
1-866-867-0700
1-866-867-0701 (TDHI)
1-866-372-1316 (Fax)

Visit our Web site @ www.pacificare.com

Employee Enrollment Form (Please Print)

California

1. Personal Information (Please print on all sections of form)

Company Name			Date of Hire	
Last Name	First Name	M.I.	Suffix	☐ Male ☐ Female
Residence Mailing Address				
City		State	ZIP	
Home Telephone	Work Telephone	Date of Birth (mm-dd-yy)		
Social Security #		Marital Status ☐ Married ☐ Widow ☐ Single ☐ Divorced ☐ Domestic Partner		
Are you currently on COBRA? ☐ Yes ☐ No If yes, qualifying event:		COBRA Qualifying Event Effective Date		
Preferred Language (optional) ☐ English ☐ Spanish				
Ethnicity (optional) ☐ Caucasian	☐ Black or African American ☐ Asian, Native Hawaiian, other Pacific Islander ☐ American Indian or Alaskan Native	☐ Hispanic or Latino ☐ Not provided by member		

Employer Required to Complete This Section

Group #/Plan Code
Source of Enrollment: ☐ Open Enrollment ☐ QMCSO ☐ New Hire ☐ Employee Status Change ☐ Rehire
Requested Effective Date
Employer Verification/Signature
Employee Class

2. Selected Coverage (Select only the plans offered by your Employer)

Medical Plan Options:

☐ PacifiCare SignatureValue (HMO) ☐ High ☐ Low
☐ PacifiCare SignatureValue - HealthCare Partners Network (HMO)
☐ PacifiCare SignatureElite (HDHP) (HSA-Compatible)
☐ PacifiCare SignatureIndependence (Indemnity)
☐ PacifiCare SignatureValue Access (EPO)
☐ PacifiCare SignatureElite (PPO) ☐ High ☐ Low
☐ PacifiCare SignatureFreedom (SDHP)
☐ PacifiCare SignatureValue Advantage
☐ PacifiCare SignatureValue Advantage PlanBien℠
☐ PacifiCare SignaturePOS

Individual(s) to be covered:

☐ Self
☐ Self + Spouse
☐ Self + Dependent(s)
☐ Self + Family
☐ Waive Medical (Complete Waiver Form)

3. Employee and Dependent Information (List yourself and family members to be covered – attach additional sheets if necessary)

Self	Primary Care Physician (PCP) Name			Provider #	Existing Patient? ☐ Yes ☐ No
Spouse/ Domestic Partner*	☐ Male ☐ Female	Last Name	First Name	M.I.	
Date of Birth (mm-dd-yy)		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name				Provider #	Existing Patient? ☐ Yes ☐ No
Dependent 1	☐ Male ☐ Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name				Provider #	Existing Patient? ☐ Yes ☐ No
Dependent 2	☐ Male ☐ Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name				Provider #	Existing Patient? ☐ Yes ☐ No
Dependent 3	☐ Male ☐ Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name				Provider #	Existing Patient? ☐ Yes ☐ No
Dependent 4	☐ Male ☐ Female	Last Name	First Name	M.I.	Date of Birth (mm-dd-yy)
Relationship		Social Security #	Address, if different from Employee's		
Primary Care Physician (PCP) Name				Provider #	Existing Patient? ☐ Yes ☐ No

Detach here

4. Benefit Coordination/Other Insurance Carrier Information

Does anyone listed have other health insurance? ☐ Yes ☐ No If yes, complete section boxes a–e

a. Name	b. Insurance Company Name	c. Policy #	d. Effective Date	e. Other Employer Name and Address

Is anyone listed eligible for Medicare? ☐ Yes ☐ No If yes, complete section boxes f–g

f. Name	g. Medicare ID#

5. Signature Required on Terms and Conditions – Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Terms and Conditions on all the pages of this form. A reproduction of this authorization shall be as valid as the original.

I DESIRE TO PARTICIPATE IN THE COVERAGES SELECTED ABOVE AND HEREBY AUTHORIZE MY EMPLOYER TO MAKE THE NECESSARY DEDUCTION(S) FROM MY WAGE/SALARY TO PAY MY PORTION OF THE PREMIUM.

Signature (Required) **X**	Date (Required)

6. Signature Required on Binding Arbitration – Read Carefully

By signing below, I acknowledge that I have read, understand and agree to the Binding Arbitration. A reproduction of this authorization shall be as valid as the original.

I AGREE AND UNDERSTAND THAT ANY AND ALL DISPUTES, INCLUDING CLAIMS RELATING TO THE DELIVERY OF SERVICES UNDER THE PLAN AND CLAIMS OF MEDICAL MALPRACTICE (THAT IS, AS TO WHETHER ANY MEDICAL SERVICES RENDERED UNDER THE HEALTH PLAN WERE UNNECESSARY OR UNAUTHORIZED OR WERE IMPROPERLY, NEGLIGENTLY OR INCOMPETENTLY RENDERED), EXCEPT FOR CLAIMS SUBJECT TO ERISA, BETWEEN MYSELF AND MY DEPENDENTS ENROLLED IN THE PLAN (INCLUDING ANY HEIRS OR ASSIGNS) AND PACIFICARE OF CALIFORNIA, UNITEDHEALTHCARE OR ANY OF ITS PARENTS, SUBSIDIARIES OR AFFILIATES SHALL BE DETERMINED BY SUBMISSION TO BINDING ARBITRATION. ANY SUCH DISPUTE WILL NOT BE RESOLVED BY A LAWSUIT OR RESORT TO COURT PROCESS, EXCEPT AS THE FEDERAL ARBITRATION ACT PROVIDES FOR JUDICIAL REVIEW OF ARBITRATION PROCEEDINGS. ALL PARTIES TO THIS AGREEMENT ARE GIVING UP THEIR CONSTITUTIONAL RIGHT TO HAVE ANY SUCH DISPUTE DECIDED IN A COURT OF LAW BEFORE A JURY, AND INSTEAD ARE ACCEPTING THE USE OF BINDING ARBITRATION.

Signature (Required) **X**	Date (Required)

Detach here

Enrollment Identification Card

UnitedHealthcare
PacifiCare

Name

Employer Name | Group Code

Doctor | Phone

- ☐ PacifiCare SignatureValue (HMO)/ PacifiCare SignatureValue - HealthCare Partners Network (HMO) PacifiCare SignatureValue Advantage / PacifiCare SignatureValue Advantage - Plan Bien (HMO) 1-800-624-8822
- ☐ PacifiCare SignaturePOS (POS) 1-800-913-9133
- ☐ PacifiCare SignatureElite (PPO)*/ PacifiCare SignatureIndependence (Indemnity)* 1-866-316-9776
- ☐ PacifiCare SignatureFreedom (SDHP)* 1-866-867-0700

Coverage shall not begin until acceptance of your enrollment by PacifiCare or PacifiCare Life and Health Insurance Co. Upon acceptance of your enrollment, PacifiCare or PacifiCare Life and Health Insurance Co. shall be bound by the terms of the Agreement or Policy and any Amendments thereto.

* Underwritten by PacifiCare Life and Health Insurance Company

Enrollment Identification Card

UnitedHealthcare
PacifiCare

Name

Employer Name | Group Code

Doctor | Phone

- ☐ PacifiCare SignatureValue (HMO)/ PacifiCare SignatureValue - HealthCare Partners Network (HMO) PacifiCare SignatureValue Advantage / PacifiCare SignatureValue Advantage - Plan Bien (HMO) 1-800-624-8822
- ☐ PacifiCare SignaturePOS (POS) 1-800-913-9133
- ☐ PacifiCare SignatureElite (PPO)*/ PacifiCare SignatureIndependence (Indemnity)* 1-866-316-9776
- ☐ PacifiCare SignatureFreedom (SDHP)* 1-866-867-0700

Coverage shall not begin until acceptance of your enrollment by PacifiCare or PacifiCare Life and Health Insurance Co. Upon acceptance of your enrollment, PacifiCare or PacifiCare Life and Health Insurance Co. shall be bound by the terms of the Agreement or Policy and any Amendments thereto.

* Underwritten by PacifiCare Life and Health Insurance Company

Complete the temporary Enrollment Identification Cards below, and keep until you receive your permanent ID card.

Detach here