SAN DIEGO UNITE-HERE HEALTH FUND

SUMMARY PLAN DESCRIPTION (SPD) AND PLAN DOCUMENT

JANUARY 1, 2025

SELF-FUNDED MEDICAL PPO BLUE PLANS, KAISER PERMANENTE HMO AND SIMNSA HMO

[REFER TO BOOKLETS PROVIDED BY KAISER PERMANENTE AND SIMNSA FOR COMPLETE DESCRIPTIONS OF THESE MEDICAL PLANS]

-Prescription Drugs
- Dental Benefit (Self-Funded and SIMNSA)
[REFER TO BOOKLET PROVIDED BY SIMNSA FOR A COMPLETE DESCRIPTION OF THIS DENTAL PLAN]
-Life Insurance
-Accidental Death & Dismemberment
Vision Benefit

Este folleto contiene un resumen en inglés de los derechos y beneficios de su Plan bajo el Fondo de Salud UNITE-HERE de San Diego. Si tiene dificultades para entender cualquier parte de este folleto, comuníquese con BeneSys Administrador, el administrador del Plan, 3737 Camino Del Rio South, Suite 300 San Diego, California 92108. El horario de servicio es de 8:00 a.m. a 5:00 p.m. de Lunes a Viernes. También puede llamar a la oficina del administrador del Plan al (619) 849-1060 para obtener ayuda.

San Diego UNITE-HERE Health Fund

3737 Camino Del Rio South, Suite 300

San Diego, California 92108

(619) 849-1060

BOARD OF TRUSTEES

Union Trustees	Management Trustees
Brigette Browning	Julie Fallon
Jorge Arellano	Jan Coppola
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Fund Administrator

BeneSys Administrators
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Fund Consultant

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Dear Participant:

The Health Plan was established in accordance with Collective Bargaining Agreements between UNITE H.E.R.E. Local 30 and participating employers. This booklet has been revised to reflect the benefits that are available to you and your family under the Health Plan (or Fund) as of January 1, 2025. It also includes the rules governing eligibility, the filing of claims for the self-funded benefits, your rights to appeal self-funded benefit denials, how benefits are funded and other information about the administration of the Health Plan as required by the Employee Retirement Income Security Act of 1974.

Some of the benefits available to you are fully insured and provided through a contract with a carrier. Other benefits are self-funded and provided directly by the assets of the Fund. This booklet details the self-funded medical PPO Blue Plan benefits, dental and vision benefits, as well as the insured death benefits. For complete information on the insured benefits, you should refer to the Evidence of Coverage booklet for each carrier; the booklets are available from the Fund Administrator.

Regardless of the funding method of benefits, none of the benefits available through the Trust are guaranteed in this form or in any form. The Trustees reserve the right to amend or terminate the type or level of benefits and eligibility rules in order to maintain the financial stability of the Plan. From time to time, the Board of Trustees may find it advisable to change the provisions of the Plan. If this occurs, you will be advised of any change. To ensure notification, you must provide (in writing) your current address to the Fund Administrative Office.

We urge you and your family to read this booklet thoroughly so you will be familiar with the enrollment procedures and how to obtain benefits. It should be kept for reference throughout the year when medical care is required. If you have questions about your benefits, eligibility or the filing of claims, please contact the Fund Administrator where the personnel will be happy to assist you.

Sincerely,

Board of Trustees

Rights of the Board of Trustees

Only the full Board of Trustees is authorized to interpret the Plan benefits described in this booklet, and no individual Trustees, Union Representative, or Employer Representative is authorized to interpret this Plan on behalf of the Board, or to act as an agent of the Board. The Trustees have authorized the Fund Administrator to respond in writing to Plan Participants regarding the administration of the Plan. As a convenience to Participants, the Fund Administrator may also provide answers regarding coverage verbally, on an informal basis. However, no such verbal communication is binding upon the Board of Trustees.

The Trustees shall have the exclusive right, power and authority in their sole and absolute discretion to administer, apply and interpret the Plan and any other Plan documents and to decide all matters arising in connection with the operation or administration of the Plan. The Trustees, in their sole discretion, may amend the Plan. Without limiting the generality of the foregoing, the Trustees shall have the sole and absolute discretionary authority to:

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

All determinations made by the Trustees with respect to any matter arising under the Plan and any other Plan documents shall be final and binding on all parties.

Discretionary Authority of the Board of Trustees

The Trustees have full discretionary authority to interpret all Trust Agreement documents and to make all factual determinations concerning any claim or right asserted under or against the Plan or Health Fund. The denial of an application or claim after the right to review has been waived or the decision of the Trustees on petition for review has been issued will be final and binding upon all parties, including you. No lawsuit may be filed without first exhausting the above appeals procedure.

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SCHEDULE OF BENEFITS

Classes of Coverage

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Life Insurance Coverage

Class 1 and Class 2 Life Insurance Benefits
Class 3 Voluntary Benefit

Benefit:

First year of Plan eligibility effective March 1 ....$2,500
Effective on first year anniversary of Plan eligibility $20,000
(For Class 1 and Class 2 benefit increases to $50,000 on March 1, 2025)

Class 1 and Class 2 AD&D Insurance
Class 3 Voluntary Benefit

Full Benefit:

First year of Plan eligibility… $1,500
Effective on first year anniversary of Plan eligibility…..... $20,000

Dependent Life Insurance for Class 1 and 2

Class 1 and Class 2
Class 3 Voluntary Benefit

Spouse (first year covered) $2,500
Effective on first year anniversary of Plan eligibility..... $10,000

Child – Age:

Under 6 months

First year covered… $500
Effective on first year anniversary of Plan eligibility…..... $2,500

6 months to year in which the child attains age 26

First year covered..…….....$2,500
Effective on first year anniversary of Plan eligibility $10,000

UNITE HERE Family Health Center Enhanced Benefits

The Trustees are extremely pleased to provide you the following enhanced benefits when using the Family Health Center and designating the Family Health Center as your primary medical care provider. If you are enrolled in the Blue Basic, Blue Select, Blue Cross Medical and Drug plans, or SIMNSA, you will receive the following medical services without making any changes by using the Family Health Center:

Benefits when using the UNITE HERE Family Health Center (FHC)				
	Blue Basic	**Blue Select**	**Blue Plus**	**SIMNSA**
Office Visits	No-Cost from Family Health Center	No-Cost from Family Health Center	No-Cost from Family Health Center	No-Cost from Family Health Center
Medication	No-cost medication from FHC formulary/ No cost thru Sav-Retail for certain medications on the clinic formulary list when prescribed by the FHC staff.	No-cost medication from FHC formulary / No cost thru Sav-Rx Retail for certain medications on the clinic formulary list when prescribed by the FHC staff.	No-cost medication from FHC formulary / No cost thru Sav-Rx Retail for certain medications on the clinic formulary list when prescribed by the FHC staff.	No-cost medication from FHC formulary / No cost thru Sav-Rx Retail for certain medications on the clinic formulary list when prescribed by the FHC staff.
Lab and Imaging Services	No-Cost lab and imaging when referred through the FHC at their preferred facility.	No-Cost lab and imaging when referred through the FHC at their preferred facility.	No-Cost lab and imaging when referred through the FHC at their preferred facility.	No-Cost lab and imaging when referred through the FHC at their preferred facility.

If you are enrolled in the Blue Basic, Blue Select, Blue Cross Medical and Drug plans, you will receive the following additional enhanced benefits when you elect the Family Health Center as your primary provider:

Benefits when you elect the Family Health Center as "Primary Medical Provider"			
	Blue Basic	**Blue Select**	**Blue Plus**
Referrals	No-Cost referrals if you have designated the FHC as your primary medical Provider.	No-Cost referrals if you have designated the FHC as your primary medical Provider.	No-Cost referrals if you have designated the FHC as your primary medical Provider.
Hospital	Hospital Co-Payment will be limited to a flat $750 ($500 copayment / $250 cap on hospital / physician ancillary benefits). The $750 cap includes hospital, all ancillary and other provider charges associated with hospitalization.	Hospital Co-Payment will be limited to a flat $750 ($500 copayment / $250 cap on hospital / physician ancillary benefits). The $750 cap includes hospital, all ancillary and other provider charges associated with hospitalization.	Hospital Co-Payment will be limited to a flat $750 ($500 copayment / $250 cap on hospital / physician ancillary benefits). The $750 cap includes hospital, all ancillary and other provider charges associated with hospitalization.
Outpatient Surgery	No special benefit paid as any other Medical expense.	Outpatient medical surgical procedures limited to a flat $375 Co-Payment when referred by the FHC to an in-network provider.	Outpatient medical surgical procedures limited to a flat $375 Co-Payment when referred by the FHC to an in-network provider.

Self-Funded Medical PPO Blue Plans				
	Basic Blue PPO Medical Plan Employee Only Coverage		**Blue Select/Plus PPO Medical Plans Family Coverage**	
	PPO Provider	**Non-PPO Provider**	**PPO Provider**	**Non-PPO Provider**
Your Monthly Self-Payment	No Self-Payment Required		Blue Select $20 self-payment per month Blue Plus $80 self-payment per month (Prescription drug buy-up plan)	
Physician Office Visit	After deductible, the Plan pays 75%.	After deductible, the Plan pays 50%.[1]	$20 member copayment per office visit	After deductible, the Plan pays 50%.[1]
Deductible	$500 Deductible per calendar year.		$100 Deductible per person per calendar year; maximum of $300 per family per calendar year. $50 deductible per person for home health care.	
Coinsurance	After deductible; Plan pays 75% of covered PPO charges.	After deductible, Plan pays 50%[1] of covered non-PPO charges, unless noted otherwise.	After deductible; Plan pays 90% of covered PPO charges.	After deductible, Plan pays 50%[1] of covered non- PPO charges, unless noted otherwise.
Out-of-Pocket Maximum (combined with prescription drug out-of- pocket expenses)	After individual out of pocket expenses reach $6,350 ($12,700 family) in a calendar year, the Plan will pay 100% of covered expenses for the remainder of the calendar year.	None	After individual out of pocket expenses reach $6,350 ($12,700 family) in a calendar year, the Plan will pay 100% of covered expenses for the remainder of the calendar year.	None

[1] Plan payments for Non PPO providers based on the Anthem Blue Cross Allowances for PPO providers providing similar services within a reasonable geographic location.

Self-Funded Medical PPO Blue Plans				
	Basic Blue PPO Medical Plan Employee Only Coverage		**Blue Select/Plus PPO Medical Plans Family Coverage**	
	PPO Provider	**Non-PPO Provider**	**PPO Provider**	**Non-PPO Provider**
In-Patient Hospital Care	After deductible; Plan pays 75% of covered PPO charges.	After deductible, Plan pays 50%[1] of covered non-PPO charges, unless noted otherwise.	$500 member copayment per admission for authorized hospitalizations.	Room & Board: Plan pays $135 per day for Employees; $100 per day for Dependents. Intensive care - $405 per day for Employees and $300 per day for Dependents Ancillary charges paid at 50%.[1]
Ambulance	After deductible; Plan pays 75% of covered PPO charges.	After deductible, Plan pays 50%[1] of covered non-PPO charges, unless noted otherwise.	After deductible, Plan pays 90% of allowed charges.	After deductible, Plan pays 80% of allowed charges.
Out-Patient Hospital Services	After deductible; Plan pays 75% of covered PPO charges.	After deductible, Plan pays 50%[1] of covered non-PPO charges, unless noted otherwise.	After deductible, Plan pays 90% of negotiated fees.	After deductible, Plan pays 50%[1].
Emergency Room	After 25% coinsurance, Plan pays 75%, for Emergency Medical Condition.	After 25% co-insurance for Emergency Medical Condition or 50% co-insurance if not Emergency Medical Condition Plan pays 75% or 50% of allowable charges.[1]	After $100 Co-Payment (waived if admitted) for Emergency Medical Condition or $250, co-pay plus 10% of charges in excess of $250 if medical condition is not an Emergency Medical Condition and can be treated at Retail Store Clinic or Urgent Care, Plan pays 100% or 90%.	After $100 Co-Payment (waived if admitted) for Emergency Medical Condition or 50% co-pay if condition is not Emergency Medical Condition, Plan Pays 100% or 50% of allowable charges.[1]

[1] Plan payments for Non-PPO providers based on the Anthem Blue Cross Allowances for PPO providers providing similar services within a reasonable geographic location.

Self-Funded Medical PPO Blue Plans				
	Basic Blue PPO Medical Plan Employee Only Coverage		**Blue Select/Plus PPO Medical Plans Family Coverage**	
	PPO Provider	**Non-PPO Provider**	**PPO Provider**	**Non-PPO Provider**
Urgent Care	After deductible, Plan pays 75% of negotiated fees.	After deductible, the Plan pays 50%[1]	$20 member Co-Payment per visit; Retail Store Clinic (CVS) $10 copayment per visit, deductible does not apply.	After deductible, 50%[1] Coinsurance.
Physician in-hospital visit Surgeon or Anesthetist			After deductible, Plan pays 90% of negotiated fees.	After deductible, the Plan pays 50%[1]
Home Health Care			After deductible, Plan pays 90% of negotiated fees.	After deductible, the Plan pays 80%[1] of allowed Charges.
X-Ray and Laboratory			After deductible, Plan pays 90% of negotiated fees.	After deductible, the Plan pays 50%[1]
Physical Exams	No Charge for certain preventive services.	After deductible, the Plan pays 50%[1] One exam per year covered up to $135 per exam.	No Charge for certain preventive services.	After deductible, the Plan pays 50%[1] One exam per year covered up to $135 per exam.
Mental Health and Substance Abuse Treatment	In-patient and out-patient care paid at the same levels as any other medical condition.		In-patient and out-patient care paid at the same levels as any other medical condition.	

[1] Plan payments for Non-PPO providers based on the Anthem Blue Cross Allowances for PPO providers providing similar services within a reasonable geographic location.

Self-Funded Medical PPO Blue Plans				
	Basic Blue PPO Medical Plan Employee Only Coverage		**Blue Select/Plus PPO Medical Plans Family Coverage**	
	PPO Provider	**Non-PPO Provider**	**PPO Provider**	**Non-PPO Provider**
Hearing Aids	100% after $50 deductible for each ear. $1,200 maximum per ear for Employee & Spouse, covered every 5 years. $1,200 maximum per ear for dependent children, covered every 3 years. Repairs, cleaning, and batteries are not covered.		100% after $50 deductible for each ear. $1,200 maximum per ear for Employee & Spouse, covered every 5 years. $1,200 maximum per ear for dependent children, covered every 3 years. Repairs, cleaning, and batteries are not covered.	
Telehealth	$0 copayment for telehealth visits through LiveHealth Online. Call 1-888-548-3432 or visit https://www.livehealthonline.com to schedule an appointment.			

Self-Funded Hearing Aid Benefit for Kaiser and SIMNSA members: 100% after $50 deductible for each ear. $1,200 maximum per ear for Employee & Spouse, covered every 5 years. $1,200 maximum per ear for dependent children, covered every 3 years. Repairs, cleaning, and batteries are not covered. You will need to submit a claim for reimbursement with the Fund Administrator.

No Surprises Act: Your cost-sharing obligation for Non-PPO Provider ("Non-PPO") claims will be capped to the applicable PPO Provider in-network cost-sharing level for the following services: (1) emergency services performed by a Non-PPO provider or facility and post-stabilization care if you cannot be moved to an in-network facility; (2) non-emergency services provided by a Non-PPO provider at in-network facilities, including hospital and ambulatory surgical centers (such services may include off-site lab, imaging, or other services associated with the visit to the in-network facility) unless you give written consent and give up your protection; and (3) air ambulance services provided by non-PPO providers. These caps are intended to protect you from balance-billing or "surprise billing" by Non-PPO providers.

PATIENT PROTECTION RIGHTS OF THE AFFORDABLE CARE ACT ("ACA")

The Self-Funded Medical PPO Blue Plans do not require the selection or designation of a primary care provider. You have the ability to visit any PPO or Non-PPO provider; however, payment by the Plan may be less for the use of a non-PPO provider.

Prior Authorization is not required in order to obtain access to obstetrical or gynecological care from a provider who specializes in obstetrics or gynecology.

Prescription Drug Benefits

Prescription Drug benefits are provided for Participants enrolled in the Blue Basic, Blue Select and Blue Plus Plans through a service contract with Sav-Rx. A list of contracting pharmacies is available without charge from the Fund Administrator. If you use a non-contracting pharmacy, you may have your claim submitted to Sav-Rx for processing. The maximum direct member reimbursement will be 60% of the average amount allowed for a prescription drug in a geographic area based on the Sav-Rx average contract discounts, less the applicable co-payment.

Maximum Out of Pocket Maximum

After individual out of pocket expenses for eligible PPO medical and prescription drug expenses reach $6,350 ($12,700 family) in a calendar year, the Plan will pay 100% of covered expenses for the remainder of the calendar year.

Out-of-Pocket expenses for Prescription Drugs will not include expenses for drugs not covered under the Plan or financial penalties imposed for non-compliance with the step therapy or generic substitution features of the program.

Blue Basic and Blue Select Plans	
Generic Drugs	**Retail Store (up to a 30 day supply) or Mail Order (31-90 day supply)**: You pay a $10 copayment for Retail Store or Mail Order, deductible does not apply. Certain generic drugs will be available at $0 copayment at the Family Health Center, the list of drugs covered at no charge may change from time to time.
Preferred Brand Drugs	**Retail Store (up to a 30 day supply) or Mail Order (31-90 day supply):** The following classes of brand drugs require trial and failure of at least one generic: statins, SSRI, antidepressants, ARB/ACE, sleep aids, proton pump inhibitors. Certain Preferred Brand Drugs may be available at no cost at the Family Health

Preferred Brand Drugs Cont'd	Certain Preferred Brand Drugs may be available at no cost at the Family Health Center, the list of drugs covered at no charge may change from time to time. If no generic is available you pay a 20% coinsurance minimum of $15 Retail Store or Mail Order. ***If a generic is available and you receive a brand name Drug, you pay $30 plus the cost difference between the generic and brand name Drugs.***
Specialty drugs	20% coinsurance minimum of $15 mail order. Deductible does not apply. Covers up to a 30-day supply mail order prescription only. Pre-authorization is required.

Blue Plus Plan	
Generic Drugs	**Retail Store (up to a 30 day supply) or Mail Order (31- C 90 day supply)**: You pay a $15 copayment for Retail Store or Mail Order, deductible does not apply. Certain generic drugs will be available at no cost at the Family Health Center. The list of drugs covered at no charge may change from time to time.
Preferred Brand Drugs	**Retail Store (up to a 30 day supply) or Mail Order (31- 90 day supply)** If no generic is available you pay a $30 copayment. The following classes of brand drugs require trial and failure of at least one generic: statins, SSRI, antidepressants, ARB/ ACE, sleep aids, proton pump inhibitors. Certain Preferred Brand Drugs may be available at no cost at the Family Health Center, the list of drugs covered at no charge may change from time to time ***If a generic is available and you receive a brand name Drug, you pay $30 copayment for Retail Store or Mail Order plus the cost difference between the generic and brand name Drugs.***
Specialty drugs	$15/$30 copayment. Deductible does not apply. Covers up to a 30-day supply mail order prescription only. Pre-authorization is required.

Prior Authorization and Step-Therapy Requirements:

Call (800) 228-3108 for prior authorization and step-therapy drug information, as described below.

SPECIALTY DRUG: All specialty drugs are required to be obtained through the Sav-Rx Specialty Pharmacy by mail order for up to a 30-day supply for each prescription fill or refill. If the specialty drug you are using is part of the High Impact Advocacy Program, you will be required to enroll in this program. Sav-Rx will assist you with your enrollment into the High Impact Advocacy program, which is a manufacturer-sponsored coupon program. If you have any questions regarding the Sav-Rx Specialty Pharmacy, please call (800) 228-3108.

Step-Therapy: The trial and failure of at least one generic for the following therapeutic classes is required before other brand name prescriptions are covered: Statins (high cholesterol), SSRI Antidepressants, ARB/ACE (blood pressure), Sleep Aids, and Proton Pump Inhibitors (gastric reflux).

REGARDLESS OF THE COPAYMENT AMOUNTS SHOWN, PRESCRIBED MEDICATIONS FOR PREVENTIVE HEALTH WILL BE PROVIDED WITH NO COPAYMENT. REFER TO WEBLINK ON PAGE 41 TO VIEW THE MOST CURRENT LIST OF PREVENTIVE HEALTH MEDICATIONS.

CHOICE OF PLANS

You will receive I.D. card(s) that identify the benefit plan you have selected.

Active Employees

Depending on the terms of the Collective Bargaining Agreement governing your employment and participation in the Plan, you may be able to opt-out of coverage through the Plan provided you submit proof of other sufficient employer group coverage and complete and return an "Opt-out Form" to the Administrative Office. Please note if you elect to opt-out of coverage with the Plan in a given year, you may only be permitted to opt back into the Plan's coverage during a Special Enrollment period. Contact the Administrative Office for procedures on enrollment after an opt-out.

As a new employee, your choice of medical plans are the 1) Blue Basic, 2) Blue Select, 3) Blue Plus Plans or 4) SIMNSA HMO Medical Plan. If you enroll in the Blue Select, Blue Plus or SIMNSA HMO Plans or one of the dental plans, all of your family members must be enrolled in the same medical and dental plan as you if they are to be covered. ***Any newly eligible Employee not making a selection within the first 90-days of becoming eligible will be enrolled for Employee only benefits under the Blue Basic PPO Medical and Prescription Drug Plans.***

There is no dependent coverage under the Blue Basic PPO Medical Plan and there will be no coverage for Life and AD&D Insurance Benefits, Dental or Vision benefits for you or your family members.

Once you have been enrolled in a plan for a minimum of 12 consecutive months, you will have the option of changing your benefit plan ("12-Month Rolling Open Enrollment"). You should be certain to discuss the options with your family members before you make your selection. The 12-Month Rolling Open Enrollment allows you to change your medical plan enrollment or your dental plan enrollment (or both) but any change can only be made once in a 12-month period (e.g. if you changed your medical plan in January but not your dental plan, you cannot change your dental plan until the next January or later. At that time, you can change both plans or only one plan).

Retired Employees

If you are retiring from active employment and you wish to continue your coverage, you will remain in the medical plan you had as an Active Employee, however, you will no longer be eligible for Vision coverage. Dental and Life Insurance benefits are available at an additional cost. You can change plans once you have been continuously covered under the existing plan for a minimum of 12 consecutive months, including your months of coverage as an Active Employee. **You must request Retired Employee coverage – it is not automatic. If you do not elect coverage when it is first offered, you will not be able to elect it in the future**. Retired Employees and their dependent spouses age 65 or older are required to have Medicare Parts A and B to be covered and will not be able to select or continue coverage under the SIMNSA HMO Plan.

Medical Plan Choices

Self-Funded PPO Medical Plans

If you elect one of the Blue PPO Medical Plans, you can use any Doctor or Hospital of your choice but your out-of-pocket expenses are higher if you use a Non-Preferred Provider. If you select this plan, you will receive your Prescription Drugs through Sav-Rx. You will continue to be covered for Life Insurance and Vision benefits if you elect coverage under the Blue Select or Blue Plus PPO Medical Plans. ***Life and AD&D Insurance, Dental benefits and Vision benefits or dependent medical benefits are not provided to those enrolled under the Blue Basic PPO Medical Plan***.

If you are enrolled in the PPO medical plan and are residing or traveling outside of California, you may receive coverage through the Blue Card PPO network. (the benefit plans are the same). To access the network or locate providers:

Call: 1 (800) 810-2583 or use these websites:

www.bluecares.com (Doctor & Hospital Finder)

www.anthem.com (click on Out of State hyperlink)

Warning: If you do not make an election for medical coverage, or if you fail to make the required self-payments for the Blue Select and Blue Plus PPO Medical Plans, you will be enrolled in the Blue Basic PPO Medical Plan with Employee Only coverage and you will not be allowed to change your election until the next 12-Month Rolling Open Enrollment period or during the annual Dependent Open Enrollment (if you are adding dependents), unless you experience a Special Enrollment Right under HIPAA.

HMO Medical Plan Choices

The Fund currently has a contract with two Health Maintenance Organizations (HMOs). If you select one of the Trust's HMO plans (SIMNSA or Kaiser), you will also receive your Prescription Drugs through that HMO. The HMO Medical Plan options are:

- **Kaiser Permanente HMO Plan –** Closed to new enrollment unless you are an employee of a newly contributing employer who offered Kaiser at the time you commenced participation in the Trust. You must live within the Kaiser service area to be enrolled in this plan. You must use Kaiser Doctors and Hospitals, except in an Emergency or if authorized by your Kaiser. The Kaiser service area is 30 miles from a Kaiser medical facility. Generally, you must reside in California. All family members must be enrolled in the same plan. A list of Kaiser medical facilities is available at no charge from the Fund Administrator. **A monthly self-payment is required. If you elect this coverage and fail to make a self-payment for two consecutive months, you will be placed in the Blue Basic PPO Medical Plan (Employee only coverage) and you will not be able to re-enroll in Kaiser. Certain exceptions for Kaiser enrollment are available for employees of Marriott La Jolla and Intercontinental San Diego through March 2026. Please contact the Fund Office for information.**

- **SIMNSA** – A health care plan that provides Hospital and medical care for those Participants who live within 50 miles of Tijuana, Tecate or Mexicali, Mexico. If you select this plan, you must receive all of your care from SIMNSA providers except in the case of an Emergency with approval of the SIMNSA health plan. You do not have to reside in Mexico to enroll in this plan. All family members must be enrolled in the same plan. A list of SIMNSA providers is available at no charge from the Fund Administrator.

Dental Plan Choices

Participants may opt out of dental and vision (with no change in their premium). Contact the Fund Administrator for more information.

If you select either the Blue Select PPO Medical Plan, Blue Plus PPO Medical Plan, Kaiser HMO Plan or the SIMNSA HMO Medical Plan, you have the following choice of dental plans. Retiree Employees must select and pay for dental coverage.

- **Self-Funded Dental Plan –** If you elect this dental plan, you can use any licensed dental provider. Benefits will be paid according to the dental schedule of allowance and the benefit percentages outlined beginning on page 65. All family members must be enrolled in the same plan. The Trust also has a contract with First Dental Health which provides access to their network of Exclusive Providers (EPO). Benefits will be paid according to the amounts negotiated by First Dental Health and the benefit percentages outlined on page 65. If you meet or exceed your annual benefit maximum, and use a First Dental Health Provider, you will only be charged up to the amount shown in the schedule of allowances.

  Self-Funded Dental Plan – Family Health Center If you use the Family Health Center Dental office, you will not be required to pay any copayments until you meet or exceed your annual benefits maximum. If you elect the Family Health Center dentist as your primary provider, you will receive a higher maximum annual allowance as noted in the schedule of benefits. In addition, you will have a maximum co-payment of $600 for covered Dependent Child orthodontic procedure. Implants are covered at the Family Health Center at $800 co-payment.

Self-Funded Dental Plan – Bonita Office Self-Funded Plan enrollees have the option to obtain the services from the Bonita Dental office who has a contract directly with the Trust. By virtue of this contract, the deductible will be waived for preventive and diagnostic services and $25 of the $50 annual deductible for basic and major dental services will be waived. The dental office shall accept the Plan's schedule of allowances as payment in full. You may obtain a copy of the schedule of allowances from the Fund Administrator. If you meet or exceed your annual benefit maximum, you will only be charged up to the amount shown in the schedule of allowances. All other provisions, exclusions and limitations of the Plan shown beginning on page 66 under Self-Funded Fee-For-Service Dental Benefits apply.

- **SIMNSA Dental Plan –** If you enroll in this dental plan, you must live within 50 miles of a SIMNSA dental facility and receive all of your dental care from the Dentists under contract with SIMNSA. NEW ENROLLEES MAY ELECT THE SIMNSA DENTAL PLAN ONLY IF THEY ARE ALSO ENROLLED IN THE SIMNSA MEDICAL PLAN.

Warning: If you are eligible to enroll in a dental plan and fail to select a plan, you will be enrolled in the Self-Funded Dental Plan (provided that you have not opted out of dental coverage) and you will not be allowed to change dental plans for twelve- consecutive months.

Enrollment Requirements

When you become eligible, you will be asked to complete a Trust enrollment form as well as enrollment forms as may be required by the Trust for the medical and dental plans you select. You must enroll all Dependents that you want to cover and provide proof of dependency (copy of a certified marriage license for your spouse or an Affidavit of Domestic Partnership for your Domestic Partner and a copy of a certified birth certificate for each Dependent child) regardless of the plan of benefits you select. If you fail to enroll your Dependents, you will not be allowed to enroll them until the next Dependent Open Enrollment Period (with proof of dependency) unless you experience a Special Enrollment event. See page 101 for Special Enrollment Rights under HIPAA. In addition, you are allowed to terminate coverage for a Dependent only during the annual Dependent Open Enrollment Period, unless the Dependent loses coverage due to loss of dependent status during the year, or for your spouse if he/she obtains other group health coverage or is enrolled in Medicare.

If you are eligible for Life Insurance, you will also be asked to complete a beneficiary card for your life insurance. This is the person or persons you wish to be the beneficiary of your life insurance in the event of your death. In the event of your death, benefits will be paid to the last listed beneficiary. Remember, if you wish to change your beneficiary, you must contact the Fund Administrator for a new beneficiary card and submit it.

Address Changes

It is very important that the Fund Administrator has a current mailing address for you so that you can receive important information about changes to your benefit plans or eligibility rules. Be sure to notify the Fund Administrator in writing of any change of address for you or a Dependent.

Employee Eligibility

Initial Eligibility, Effective Date and Continuing Eligibility

If your Employer contributes to the Trust based on hourly contributions, you will become eligible for coverage under the Plan as an Active Member on the first day of the second month following three consecutive months in which you have at least 270 hours reported and paid by a contributing employer provided you are in a job classification covered by the terms of a Collective Bargaining Agreement.

You will continue eligibility for coverage if you have at least 90 work hours each month. Coverage will be extended on the first day of the second month following the month for which your employer reports you worked at least 90 hours.

For example, if you work a total of at least 270 hours during the months of January, February and March; then you will become eligible for coverage starting with the month of May. Once you earn initial eligibility, you must have at least 90 work hours each month to extend coverage. For example, if you work 100 hours in April, then you have earned coverage for the month of June.

If your Employer contributes to the Trust based on monthly contributions, you will become eligible for coverage under the Plan as an Active Member on the first day of the second month following the first monthly contribution paid on your behalf by a contributing employer provided you are in a job classification covered by the terms of a Collective Bargaining Agreement.

You will continue eligibility for coverage if you continue to work the required hours for which a monthly contribution is payable. Coverage will be extended on the first day of the second month following the month for which a contribution is payable.

For example, if the Trust receives a contribution on your behalf for the month of January, then you will become eligible for coverage starting with the month of March. Once you earn initial eligibility, you must work the number of required hours for which a contribution is payable to the Plan to extend coverage each month. For example, if you work the required number of hours in February, then you have earned coverage for April.

NEWLY PARTICIPATING EMPLOYER ELIGIBILITY AND EFFECTIVE DATE

If you are employed on the date a contributing employer first begins contributing to the Trust, you will be eligible for coverage on the first day of the following month, if you have worked for the employer at least 90 hours during the month of the employer's first contributions of this Trust. If you have not worked the required number of hours, you will be required to satisfy the eligibility requirements explained in the preceding paragraph.

For example, your Employer begins contributions to the Trust starting with the month of January. If you worked a total of at least 90 hours in the month of January, you will be eligible for coverage on February 1st. If you did not work 90 hours in January, you will be required to gain initial eligibility as described above by working at least 270 hours in three consecutive months.

The eligibility rules may vary due to the Collective Bargaining Agreement for some employers, including those that contribute a flat monthly contribution rate to the Trust. If you have questions regarding your requirements after you have read the Collective Bargaining Agreement, please contact the Fund Administrative Office.

Partners & Proprietors, and Employees Not Covered Under a Collective Bargaining Agreement Initial Eligibility

1. The contributing employer must complete a Participation Agreement, apply to the Board of Trustees for participation, and be granted the right to participate by the Board of Trustees.

2. You must be in a job classification not covered by the terms of a Collective Bargaining Agreement and be classified as an executive, administrative, clerical or supervisory Employee.

3. All new persons in this classification must be enrolled on the first monthly report to the Health Fund.

4. The Board of Trustees will determine the contribution rate for participation, based on the cost of purchasing benefits for persons in this classification. The rate is subject to change from time to time.

5. In order to maintain eligibility, contributions must be paid for all persons each month, by the due date, and their names must be included on the monthly employer remittance form.

6. There are two separate classifications of Participants under Participation Agreements:

    a. Partners and proprietors; and
    b. Employees not covered under a Collective Bargaining Agreement.

If there is more than one working partner in an establishment, all working partners must enroll, or none may enroll. Each classification is separate. Participation is open only to persons who are actively working in the business. Partners or proprietors who are not actively working are not permitted to be covered under the Plan. Actively working is defined as working a minimum of 20 hours per week.

Employees included in these classifications that have other health insurance coverage available, and submit proof of such coverage to the Fund Administrative Office, may waive the coverage provided under this Plan. The waiver must be made in writing on a form provided by the Fund Administrative Office. Employees who waive coverage under this provision may apply for reinstatement of health and dental coverage under this Plan within 30 days of termination of coverage by the other plan, provided proof of termination is submitted to the Fund Administrative Office.

If a contributing employer does not elect to cover himself/herself and any Participants not covered by the Collective Bargaining Agreement when enrollment is first offered, the employer may not enroll for coverage again unless the Board of Trustees elects to re-open enrollment for this class of Participants in the future.

Effective Date of Coverage, Required Enrollment, Benefits Available for Bargaining and Non-Bargaining Employees

The effective date of your coverage is the date you satisfy the initial eligibility rules.

When you first qualify for coverage, you will automatically be enrolled in the Blue Basic PPO Medical Plan and the Sav-Rx Prescription Drug benefit; ***unless you have already completed your enrollment forms for another Medical Plan and have made timely self-payment of the required monthly amounts.***

If you have not enrolled in a Medical/Dental Plan when first eligible, you must enroll in one of the other Plans within 90 days of your eligibility date. If you fail to enroll within the 90-day period or enroll in a plan that requires self-payments and those payments were not received by the Fund Administrator, you will remain covered under the Blue Basic PPO Medical Plan (with no coverage for your Dependents) and you will have to wait until the 12-Month Rolling Open Enrollment Period (when you have been covered under that plan for twelve-consecutive months) or until the next Dependent Open Enrollment Period to add coverage for your Dependents.

Payroll Deduction

If you choose to enroll in any Medical Plan except the Blue Basic PPO Medical Plan or SIMNSA, you may be required to submit monthly premium self-payments. You must fill out the payroll deduction authorization form to allow a monthly deduction from your earnings if your

employer allows deductions. The premium self-payments are subject to change from time to time. You will be advised of the current premium amounts at the time you are making your election for coverage.

You must return a check **for the first two month's premium copayment** payable to the San Diego UNITE-HERE with your enrollment application and payroll deduction authorization form to the Fund Administrator.

Confirm with the Fund Administrator whether your employer allows payroll deductions. If your employer does not allow payroll deductions, it is your responsibility to remit your self-payment monthly. Payments are due the 1st day of the month for the month of coverage for which you are paying. Your personal check or cashier's check should be made payable to the "San Diego UNITE- HERE Health Fund". Payments can be made up to one month in advance. Remit Self-Payment to:

San Diego UNITE-HERE Health Fund
3737 Camino Del Rio South, Suite 300
San Diego, California 92108

If your payment is not received by the first day of the month in which it is due or within the 30-day grace period, your enrollment in the Medical Plan you selected will be terminated and your health coverage will be temporarily suspended for such calendar month. Coverage for Life and AD&D, Dental and Vision benefits will also be terminated. In addition, **all coverage for your dependents will be terminated,** including life insurance, medical, dental and vision coverage.

If your enrollment is terminated under the paragraph above, your own medical coverage only will be retroactively reinstated in the Blue Basic PPO Medical Plan as of the first day following the day in which your original medical coverage was terminated. You will remain covered in the Blue Basic PPO Medical Plan until you are eligible to change plans in accordance with the Plan's 12-Month Rolling Open Enrollment procedure.

Hour Bank and Continuing Eligibility for Bargaining Unit Active Members whose Employers Contribute on an Hourly Basis

Once you qualify for coverage, all hours of work (for which contributions are required to be paid to the Fund by contributing employers who make hourly contributions) will be credited to an hour bank account ("Hour Bank"). Each month 90-hours will be required for one-month of coverage and will be deducted from the Hour Bank.

All contribution hours in excess of the 90-hour monthly requirement for eligibility and hours insufficient for eligibility will be credited to the Hour Bank, up to a maximum of 90 hours. These hours will be used for continuing eligibility when the hours you work are insufficient for coverage.

If your employment terminates, coverage will end on the last day of the month following the month in which employment is terminated by a contributing employer and your Hour Bank will be forfeited.

Self-Pay Option for Bargaining Unit Active Members

If the hours in your Hour Bank plus any hours you work total at least 60-hours, you may self-pay the difference between those hours and the 90-hours required for eligibility. It is your responsibility to initiate self-payment – no final notice of termination of eligibility will be sent to you; however, you will receive a notice of your rights to continue coverage under COBRA. You should contact the Fund Administrator for the exact amount of your self-payment. Your self-payment will be due by the last day of the coverage month. Payments should be sent to:

San Diego UNITE-HERE Health Fund
3737 Camino Del Rio South, Suite 300
San Diego, California 92108

From time to time, the Board of Trustees will determine the maximum monthly hourly requirement needed to support the benefit program, plus operating expenses.

Reinstatement For Hourly Contribution Participants

If your eligibility for coverage ends for any reason, you will again become eligible for coverage on the first day of the second month, following a month in which you have at least 90 hours of work reported by your employer. You must return to work within six months and regain coverage by the eighth month of the date coverage ended or you will have to satisfy the initial eligibility rules again. When you re-qualify, you will have to select your medical and dental plans or you will be placed into the Blue Basic PPO Medical Plan and the Sav-Rx Prescription Drug benefit without dependent coverage and without Life and AD&D coverage, dental coverage or vision coverage.

Uniformed Services Employment and Re-Employment Rights Act of 1994

Regardless of any existing contrary Plan provisions, the Plan shall be maintained in compliance with all requirements of the Uniformed Services Employment and Re-employment Rights Act of 1994. In no event shall benefits be provided for Illnesses or injuries determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. Unless the terms of the Collective Bargaining Agreement require otherwise, the following policies shall govern contributions for coverage and benefits under USERRA.

1. Participants who wish to elect continued coverage during a period of military service may obtain such coverage for a maximum of 24-months; however, the participant will be

responsible for the premium for up to the 24-month continuation coverage required under 38 U.S.C. 4317 at the Fund's current COBRA premium rates.

2. The employer shall provide coverage through contributions to cover the Employee whose military service is for less than 31 days.

3. The employer shall provide, through contributions, any seniority based benefits of the Plan to which an Employee is entitled due to the provisions of USERRA.

4. Upon discharge from uniformed service, an Employee who is re-employed with a contributing employer in accordance with the provisions of USERRA shall be entitled to coverage under the Plan, and all rights and benefits under the Plan the Participant would have attained if they had remained continuously employed with a contributing employer. The employee shall notify the Trustees of his or her return to work for a contributing employer within ninety (90) days of the date of the employee's honorable discharge from uniformed service if the period of service was more than 180 days or 14 days from the date of discharge if the period of service was 31 days or more but less than 180 days or at the beginning of the first of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if the period of service was less than 31 days .

Family Medical Leave Act Provision

It will be the responsibility of your employer to maintain the required contributions to the Plan on your behalf if you qualify for coverage under the Family Medical Leave Act ("FMLA"). It will be your responsibility to notify the Fund that FMLA leave will be taken, and the commencement date and duration of such leave. It is not the role of the Fund to determine whether or not an individual employee is entitled to FMLA leave. Disputes as to the entitlement to leave with continuing medical benefits must be resolved by the employer, employee and where applicable, the local union.

The contribution rate shall be equivalent to your current cost of coverage at the time you go on leave in accordance with FMLA, subject to any increase or decrease resulting from any subsequent Open Enrollment and/or amendments to the Plan.

In general, FMLA allows you to take up to 12 weeks of unpaid leave during a 12 month period due to:

1. The birth of a child or placement of a child with you for adoption or foster care;

2. The care of a seriously ill spouse, parent, or child;

3. Your own serious illness; or

4. Due to any qualifying exigency (as the Secretary of the Department of Labor shall determine by regulation) arising out of the fact that your spouse, child or parent is on active duty (or has been notified of an impending call or order to active duty) in the Armed Forces in support of a contingency operation.

Also, if your spouse, child, parent or next of kin suffers a serious injury or illness in the line of duty while on active duty in the Armed Forces you will be entitled to take up to 26 weeks of leave during a 12-month period to care for the injured service member. The maximum combined total leave entitlement that you are entitled to take under the FMLA during a 12-month period is 26 weeks.

Termination of Eligibility for Active Members, Self-Pay and Non-Bargaining Unit Members

Your eligibility will terminate on the earliest of following:

1. If employment did not end due to termination, the last day of the month in which your Hour Bank contains insufficient hours to continue eligibility if you did not elect coverage on a self-pay basis;

2. If employment ended due to termination, including voluntary termination, the last day of the month following the month in which employment is terminated by a contributing employer.

3. The date your employer ceases to be a contributing employer.

4. The last day for which the contributions have been paid for your benefits if you are a non-bargaining unit member;

5. The date you begin active duty in the armed forces of any country, except as required under USERRA.

6. The last day of the month for which you made a self-payment for coverage if you are continuing coverage on a self-pay basis.

7. The date the Plan is terminated.

If coverage is lost, you may be entitled to continued coverage under the terms of COBRA. (Refer to page 27 for details.)

Eligible Dependents of Active Members, Self-Pay and Non-Bargaining Unit Employees

The eligible Dependents of an Active Member, Self-Pay or Non-Bargaining Unit Employee include:

1. Your lawful spouse to whom you are legally married and from whom you are not legally separated;

2. Your Domestic Partner (either same sex or opposite sex) who satisfies the requirements for coverage and who has completed an Affidavit of Domestic Partnership. If you are registered as Domestic Partner with a local or state government entity, you may provide your Domestic Partner Registration and do not need to complete an Affidavit of Domestic Partnership;

3. Your natural child or children of your Domestic Partner under the age of 26. Dependent children include stepchildren, adopted children and children placed with you for adoption. In addition, if you are required to provide benefits for a child on the basis of a Qualified Medical Child Support Order (QMCSO), the child will also be covered for benefits.

4. Your unmarried child or child of your Domestic Partner who is age 26 or older and who is dependent upon you for support and is incapable of self-sustaining employment due to mental or physical handicap (which has been certified in writing by a Physician and approved by the Board of Trustees), provided that the mental or physical handicap existed while the child was eligible and enrolled in the Plan before age 26. In such event, the child will continue to qualify as a Dependent for all Dependent's benefits until the earlier of the following dates:

    a. The date he or she recovers from the handicap; or
    b. The date he or she is no longer chiefly dependent on you for support and maintenance; or
    c. The date you are no longer covered by the Plan.

When both a husband and wife are covered under the group Plan as eligible Employees, each may cover the other as a Dependent spouse, and each may cover their Dependent children.

Effective Date of Coverage and Required Enrollment

In order to enroll your Dependents, you must elect coverage under one of the Medical Plans available to you, except the Blue Basic PPO Medical Plan which does not cover Dependents.

You must enroll all of your Dependents in order to cover any Dependents. Dependents may be covered for all benefits available to you, except for Accidental Death and Dismemberment.

Provided a completed enrollment form is submitted timely to the Fund Administrator,

The effective date of coverage for each of your Dependents is the later of:

1. the effective date of your coverage if enrolled and qualified as a Dependent on that date; or
2. the date they qualify as your Dependent if acquired and enrolled after your effective date.

If you are eligible to enroll your Dependents but fail to enroll a Dependent when first eligible, you may enroll such Dependent in the Plan during the Dependent Open Enrollment month of June of each year (August 1 effective date) or at such time as required under the Special Enrollment section on page 101.

Termination of Eligibility for Dependents of Active Members, Self-Pay and Non-Bargaining Unit Members

Your Dependent's eligibility will terminate on the earliest of the following dates:

1. The date your eligibility ends;
2. The date on which the person no longer qualifies as a Dependent; provided that coverage for a Dependent Child who no longer qualifies due to reaching age 26 will terminate at the end of the month in which the Dependent Child attains age 26;
3. The date your Domestic Partnership terminates;
4. The date your employer is no longer a contributing employer;
5. The date the Plan terminates benefits for Dependents; or
6. The last day of the month for which any required self-payment was made.

If coverage is lost, you may be entitled to continued coverage under the terms of COBRA. (Refer to page 27 for details). COBRA coverage is not available to Domestic Partners or their dependent children, unless you are covered under the Kaiser HMO Medical Plan, in which event Cal-COBRA rights are applicable for a period of 36 months.

Retired Employee's Eligibility

If you are a former Active Member of a contributing employer, and you satisfy the eligibility rules, you can be covered as a Retired Employee under the Plan. You must elect Retired Employee's coverage; it is not automatic. Coverage will be provided for you, your eligible spouse and eligible Dependent children provided you remain eligible and make the required self-payment for coverage.

An Eligible Retired Employee:

1. Is 55 years of age or older; and

2. Has been eligible for health benefits under the Plan for twelve (12) of the last twenty-four (24) months immediately preceding the date of retirement; and

3. Has been approved to receive benefits from the San Diego UNITE-HERE Pension Fund; or

4. Has qualified as an eligible Active Member under the Plan for a total of 120 months and was eligible for health benefits under the Plan for at least one year immediately prior to the date of retirement.

Benefits for Retired Employees

Retired Employees are eligible for medical benefits. On a full self-pay basis, they may elect life insurance and dental benefits.

Retirees may enroll in any of the Medical Plan options available, except enrollment in the SIMNSA medical plan is not allowed for those age 65 or older.

Effective Date of Coverage, Required Enrollment and Self-Payment

Retired Employees must elect to continue their health coverage within ninety (90) days of the date they apply for their pension under San Diego UNITE-HERE Pension Fund, and must begin paying the required premiums for coverage the month they receive their first pension check or the first month their Active Member coverage lapses. The amount of self-payment is determined by the Board of Trustees to be sufficient to cover the cost of benefits. It is subject to change from time-to-time. You will be advised in advance of any change in the self-pay amount.

If a Retired Employee elects retiree coverage and it subsequently ceases due to non-payment of the required self-payment, he or she will **not** have the opportunity to reinstate coverage at a later date unless the Retired Employee returns to active coverage as a result of returning to work for an employer who contributes to the San Diego UNITE-HERE Health Fund. In such event, the Retired Employee shall have the ability to reinstate coverage under the Retiree Plan upon the cessation of coverage as an Active Member under this Plan.

Eligible Dependents of Retired Employees

Eligible Dependents include your:

1. Your lawful spouse to whom you are legally married and from whom you are not legally separated;

2. Your Domestic Partner (either same sex or opposite sex) who satisfies the requirements for coverage and who has completed an Affidavit of Domestic Partnership. If you are registered as Domestic Partner with a local or state government entity you may provide your Domestic Partner Registration in lieu of completing an Affidavit of Domestic Partnership;

3. Your natural child or children of your Domestic Partner under the age of 26. Dependent children include stepchildren, adopted children and children placed with you for adoption. In addition, if you are required to provide benefits for a child on the basis of a Qualified Medical Child Support Order (QMCSO), the child will also be covered for benefits.

4. Your unmarried child or child of your Domestic Partner who is age 26 or older and who is dependent upon you for support and is incapable of self- sustaining employment due to mental or physical handicap (which has been certified in writing by a Physician and approved by the Board of Trustees) provided that the mental or physical handicap existed while the child was eligible and enrolled in the Plan before age 26. In such event, the child will continue to qualify as a Dependent for all Dependent's benefits until the earlier of the following dates:

    a. The date he or she recovers from the handicap; or
    b. The date he or she is no longer chiefly dependent on you for support and maintenance; or
    c. The date you are no longer covered by the Plan.

When both a husband and wife are covered under the group Plan as eligible Retired Employees, each may cover the other as a Dependent spouse, and each may cover their Dependent children.

Termination of Eligibility for Retired Employees and Their Dependents

Your eligibility will cease on the earliest of the following dates:

1. The date of your death;
2. The last day of the month for which a required contribution for coverage was made;
3. The date benefits are no longer provided for Retired Employees;
4. The date the Plan terminates.

Eligibility for your Dependents will cease on the earliest of the following dates:

1. The date of your loss of eligibility;
2. The date of divorce or legal separation or termination of a Domestic Partnership arrangement;
3. The date benefits are no longer provided for Dependents of Retired Employees;
4. The last day of the month for which a required contribution was made;
5. The date the Plan terminates.
6. The date on which the person no longer qualifies as a Dependent; provided that coverage for a Dependent Child who no longer qualifies due to reaching age 26 will terminate at the end of the month in which the Dependent Child attains age 26.

If coverage is lost, the Dependents of a Retired Employee may be entitled to continued coverage under the terms of COBRA. (Refer to details below.) COBRA coverage is not available to Domestic Partners or their dependents, unless you are covered under the Kaiser HMO Medical Plan, in which event Cal- COBRA rights are applicable for a period of 36-months.

COBRA CONTINUATION OF COVERAGE

CONTINUATION COVERAGE RIGHTS UNDER COBRA

COBRA continuation coverage 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.

Note: Domestic Partners and their dependents do not have independent COBRA rights under federal law. However, Domestic Partners and their dependents participating in SIMNSA and Kaiser have rights to continuation coverage under Cal-COBRA. If coverage is lost Domestic Partners and their dependents may be eligible to convert their Kaiser or SIMNSA coverage to an individual plan if one is offered through their insurance carrier. Cal-COBRA only applies to insured and HMO plans (not to PPO Plans).

COBRA Continuation Coverage and Qualifying Events

COBRA continuation coverage is a continuation of Plan coverage (not including life insurance) when coverage would otherwise end because of a life event known as a "qualifying event." Specific qualifying events are listed later. 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, Active Employees, and spouses of Active and Retired Employees, and dependent children of Active and Retired Employees may be qualified beneficiaries. Under the Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage. In special circumstances (the bankruptcy of the employer) retired employees may also be qualified beneficiaries.

If you are an Active 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 Active or Retired 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 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-Active or Retired Employee dies;
(2) The parent-Active Employee's hours of employment are reduced;
(3) The parent-Active Employee's employment ends for any reason other than his or her gross misconduct;
(4) The parent-Active Employee becomes enrolled 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."

A Domestic Partner and his or her dependent children who are covered under Kaiser or SIMNSA will be entitled to 36 months of coverage if the Active Employee incurs a Qualifying Event or upon termination of the Domestic Partnership relationship.

Sometimes, filing a proceeding in bankruptcy under title 11 of the United States Code can be a qualifying event. If a proceeding in bankruptcy is filed with respect to your Employer and that

bankruptcy results in the loss of coverage of any retired employee covered under the Plan, the retired employee is a qualified beneficiary under COBRA with respect to the bankruptcy. The retired employee's spouse, surviving spouse, and dependent children will also be qualified beneficiaries if bankruptcy results in the loss of their coverage under the Plan.

Notification Requirements – Employee's, Your Employer's and the COBRA Administrator's

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the COBRA Administrator has been notified that a qualifying event has occurred.

Employer's Notification Requirements

When the qualifying event is the end of employment or reduction of hours of employment, death of the employee, commencement of a proceeding in bankruptcy with respect to the employer, or enrollment of the employee in Medicare (Part A, Part B, or both), the employer must notify the COBRA Administrator of the qualifying event within 30 days of any of these events.

Employee's Notification Requirements

It is the Employee's obligation to provide the Fund with notification of a divorce, legal separation or termination of Domestic Partnership within 60 days of the date of divorce, legal separation or termination of a Domestic Partnership relationship. For the other qualifying events such as a dependent child's losing eligibility for coverage as a dependent child, you must notify the COBRA Administrator. The Plan requires you to notify the COBRA Administrator within 60 days after the qualifying event occurs. Failure to give timely notice will cause your Spouse and/ or Dependent child to lose their right to obtain COBRA continuation coverage. Such failure will result in the Employee's liability to the Plan if any benefits are paid for an ineligible person. You must send this notice to:

COBRA Administrator
3737 Camino Del Rio South, Suite 300
San Diego, California 92108
Telephone: (619) 849-1060

Depending upon the type of qualifying event, you will be required to provide: a copy of your divorce decree or legal separation; a certified copy of the death certificate; or information about a child losing eligibility because he or she no longer satisfies the rules for dependent eligibility.

The COBRA Administrator's Notification Requirements

Once the COBRA Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries; notification of your rights will be made to you within 14 days of the date the COBRA Administrator receives notice of a qualifying event.

Premium Payments

You and your eligible dependents are responsible for all premium payments for their Continuation Coverage. As allowed by federal law, the premium payment will be equal to the cost of the coverage selected plus 2% for administration (plus 50% for administration for disability extension). The COBRA rates are changed once each year on April 1st.

When COBRA Continuation Coverage Begins and Duration of Coverage

For each qualified beneficiary who elects COBRA continuation coverage, COBRA continuation coverage will begin on the date Plan coverage would otherwise have been lost.

COBRA continuation coverage is temporary continuation 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 a 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 lasts for up to 18 months. There are three ways in which this 18-month period of COBRA continuation coverage can be extended, which includes a disability extension, second qualifying event or application of Cal-COBRA.

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 during the first 60 days of COBRA continuation coverage and you notify the COBRA 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 to:

COBRA Administrator
3737 Camino Del Rio South, Suite 300
San Diego, California 92108
Telephone: (619) 849-1060

You must include the following information with your notification: A copy of the Social Security Disability Award.

Note: *Before applying for the disability extension, be sure to read the provisions of California COBRA Extension for Qualified Beneficiaries enrolled in insured medical plans in California below*.

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 Active or Retired 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 COBRA Administrator is notified of the second qualifying event within 60 days of the second qualifying event. This notice must be sent to:

COBRA Administrator
3737 Camino Del Rio South, Suite 300
San Diego, California 92108
Telephone: (619) 849-1060

Depending upon the type of qualifying event, you will be required to provide: a copy of your divorce decree or legal separation; a certified copy of the death certificate; or information about a child no longer satisfying the eligibility rules for dependents.

Grace Periods

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

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

Addition of Newly Acquired Dependents

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

If you marry while you are enrolled for COBRA, your Spouse is not a Qualified Beneficiary, but can be added for the remainder of the duration of your existing COBRA coverage. Adding a Spouse or Dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage. Contact the COBRA Administrator to add a Dependent.

Loss of Other Group Health Plan Coverage

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

The loss of coverage must be due to exhaustion of COBRA Continuation Coverage under another plan, termination as a result of loss of eligibility for the coverage, or termination as a result of employer contributions toward the other coverage being terminated. Loss of eligibility does not include a loss due to failure of the individual or participant to pay premiums on a timely basis or termination of coverage for cause. You must enroll the Spouse or Dependent within 31 days after the termination of the other coverage. Adding a Spouse or Dependent child may cause an increase in the amount you must pay for COBRA Continuation Coverage.

Early Termination of COBRA Continuation Coverage

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

1. The date the Fund no longer provides group health coverage to any of its employees;

2. The date the amount due for COBRA coverage is not paid in full on time;

3. The date the Qualified Beneficiary becomes entitled to Medicare (Part A, Part B or both) after electing COBRA;

4. The date, after the date of the COBRA election, on which the Qualified Beneficiary first becomes covered under another group health plan. IMPORTANT: The Qualified Beneficiary must notify this Plan as soon as possible once they become aware that they will become covered under another group health plan, by contacting the COBRA Administrator. COBRA coverage under this Plan ends on the date the Qualified Beneficiary is covered under the other group health plan.

5. During an extension of the maximum COBRA coverage period to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to no longer be disabled;

6. The date the Plan has determined that the Qualified Beneficiary must be terminated from the Plan for cause (on the same basis as would apply to similarly situated non-COBRA participants under the Plan).

California COBRA (Cal COBRA) Extension for Insured and HMO Plans – Medical Benefits

California law requires insured plans to provide up to 36 months (combined federal and state COBRA extensions) of continued medical coverage. When you elect Cal COBRA, your medical plan will not include prescription drug benefits. Cal COBRA legislation does not apply to vision or dental coverage or any benefits that are not insured. The Cal COBRA extension will affect you if you have an 18- month or 29-month COBRA Qualifying Event.

In order to be eligible for the Cal COBRA extension, you must have exhausted your federal COBRA coverage. You will be charged premiums that are consistent with the California law (generally 110% of the cost of coverage).

Conversion Option for Insured Plans

When your coverage ends, you have the option of converting your group coverage to an individual plan if conversion is available. You have 60 days to convert your coverage. You should contact your insurance carrier for information on conversion plans and their costs prior to the date of your loss of coverage. Conversion plans do not provide the same level of coverage as the plan for Active or Retired Employees and dependents, and they generally cost more.

Other Coverage Options

Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicare, Medicaid, Children's Health Insurance Program (CHIP), or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Enrolling in Medicare Instead of COBRA Continuation Coverage

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

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

For more information regarding Medicare special enrollment, please visit: https://www.medicare.gov/sign-up-change-plans/how-do-i-get-parts-a-b/part-a-part-b-sign-up-periods.

If you don't enroll in Medicare and elect COBRA continuation coverage instead, you may have to pay a Part B late enrollment penalty and you may have a gap in coverage if you decide you want Part B later. If you elect COBRA continuation coverage and later enroll in Medicare Part A or B before the COBRA continuation coverage ends, the Plan may terminate your continuation coverage. However, if Medicare Part A or B is effective on or before the date of the COBRA election, COBRA coverage may not be discontinued on account of Medicare entitlement, even if you enroll in the other part of Medicare after the date of the election of COBRA coverage. If you are enrolled in both COBRA continuation coverage and Medicare, Medicare will generally pay first (primary payer) and COBRA continuation coverage will pay second. Certain plans may pay as if secondary to Medicare, even if you are not enrolled in Medicare.
For more information visit https://www.medicare.gov/medicare-and-you.

If You Have Questions

If you have questions about your COBRA continuation coverage, you should contact:

COBRA Administrator
3737 Camino Del Rio South, Suite 300
San Diego, California 92108
Telephone: (619) 849-1060

Or you may 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 and the COBRA 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 COBRA Administrator.

Notice of Privacy Practices

1. Permitted Uses and Disclosures of PHI

This Plan and its Business Associates will use and disclose PHI without your authorization for purposes of treatment, payment and health care operations, but only the minimum amount of PHI necessary to accomplish these activities. Treatment includes but is not limited to the provision, coordination or management of health care among health care providers or the referral of a patient from one health care provider to another. Payment includes but is not limited to actions concerning eligibility, coverage determinations, coordination of benefits, adjudication of health benefit claims (including appeals), determinations of cost- sharing amounts, utilization reviews, medical necessity reviews, preauthorization reviews, and billing and collection activities. Health care operations include but are not limited to performing quality assessment reviews, implementing disease management programs, reviewing the competence or qualifications of health care professionals, underwriting, premium rating and other insurance activities relating to creating or renewing insurance contracts. It also includes legal services and auditing functions for the purpose of creating and maintaining fraud and abuse programs, compliance programs, business planning programs, and other related administrative activities.

2. Required Uses and Disclosures of PHI

This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of U.S. Department of Health and Human Services ("HHS") and its Office of Civil Rights ("OCR") or other authorized government organizations to investigate or determine this Plan's compliance with the Privacy Rule.

3. Allowed Uses and Disclosures of PHI For Which Authorization or Opportunity to Object is Not Required

This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker's compensation programs and correctional facilities. These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Copies of these documents may be obtained from the Administration Office.

4. Your Individual Rights

HIPAA and the Privacy Rule afford you the following rights:

- You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request unless the total cost of the relevant item or service was paid by you out-of-pocket. If this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction.

- You (or your personal representative) have the right to request to receive communications of PHI from this Plan either by alternative means or at alternative locations. This Plan may agree to accommodate any such request if it is reasonable. This Plan, however, must accommodate such a request if you clearly state that the disclosure of all or a part of the PHI could endanger you. You will be required to complete a request form to receive communications of PHI by alternative means or at alternative locations.

- You (or your personal representative) have the right to request access to your PHI contained in a Designated Record Set, for inspection and copying, for as long as this Plan maintains the PHI. A Designated Record Set includes the medical billing records about you maintained by or for a covered health care provider, enrollment, payment, billing, claims adjudication, and case or medical management record systems maintained by or for this Plan or other information used in whole or in part by or for this Plan to make decisions about you. Information used for quality control or peer review analyses and not used to make decisions about you are not in the Designated Record Set and therefore not subject to access. The right to access does not apply to psychotherapy notes or information compiled in anticipation of litigation. You must complete a request form to access PHI in a Designated Record Set. If access to inspect and copy PHI is granted, the requested information will be provided within 30 days if the information is maintained onsite or within 60 days if the information is maintained offsite. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. This Plan may charge a reasonable fee for the costs of copying. If access to inspect and copy your PHI is denied, a written denial will be provided setting forth the basis for the denial, a description of how you may have the denial reviewed, if applicable, and a description of how you may file a complaint with this Plan or the HHS or its OCR.

- You (or your personal representative) have the right to request an amendment to your PHI in a Designated Record Set for as long as the PHI is maintained in a Designated Record Set. You will be required to complete a request form to amend PHI in a Designated Record Set. This Plan has 60 days after the request is made to act on the request. A single 30-day extension is allowed if this Plan is unable to comply with the deadline. If the request is denied in whole or in part, the Plan must provide a written denial that explains the basis for the denial. You may then submit a written statement disagreeing with the denial and have that statement included with any future disclosures of your PHI.

- You (or your personal representative) have the right to request an accounting of disclosures of PHI by this Plan. This Plan will provide such an accounting only for the six-year period preceding the date of the request. However, such accounting will not include PHI disclosures made to carry out treatment, payment or health care operations or made to you about your own PHI. Also, this Plan is not required to provide an accounting of disclosures pursuant to an authorization request or disclosures made prior to the compliance date of the Privacy Rule. You will be required to complete a request form to obtain an accounting of PHI disclosures within 60 days of the request. If the accounting cannot be provided within 60 days, an additional 30 days is allowed if you are given a written statement of the reasons for the delay and the date by which the account will be provided. If more than one request for an accounting is made within a 12-month period, this Plan will charge a reasonable, cost-based fee for each subsequent accounting.

- You will receive a notice if a breach of your PHI occurs.

5. Access by Personal Representatives to PHI

This Plan will treat your personal representative as you with respect to uses and disclosures of PHI, and all the rights afforded you by the Privacy Rule, under certain circumstances, but only to the extent such PHI is relevant to their representation. For example, a personal representative with limited health care power of attorney regarding specific treatment, such as use of artificial life support, is your representative only with respect to PHI that relates to decisions concerning this treatment. The personal representative will be required to produce evidence of authority to act on your behalf before the personal representative will be given access to PHI or allowed to take any action.

Proof of such authority may take the form of a notarized power of attorney for health care purposes (general, durable or health care power of attorney), a court order of appointment as your conservator or guardian, an individual who is the parent, guardian or other person acting in loco parentis with legal authority to make health care decisions on behalf of a minor child, or an executor of the estate, next of kin, or other family member on behalf of a decedent.

This Plan retains discretion to deny a personal representative access to PHI if this Plan reasonably believes that you have been or may be subjected to domestic violence, abuse, or neglect by the personal representative or that treating a person as your personal representative could endanger you. This also applies to personal representatives of minors. Also, there are limited circumstances under state and other applicable laws when the parent is not the personal representative with respect to a minor child's health care information.

6. This Plan's Duties

In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Administration Office has designated this group of employees to include all employees dealing with the Trust. The employees described above may only have access to and use and disclose PHI for plan administration functions. A process shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan is required by law to provide you with its Notice of Privacy Practices ("Notice") upon enrollment, and thereafter, upon request. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

This Plan will make reasonable efforts not to use, disclose or request more than the minimum amount of PHI necessary to accomplish the intended purpose of the use, disclosure or request, taking into consideration practical and technological limitations. This minimum necessary standard, however, will not apply to disclosures to or requests by a health care provider for treatment purposes, disclosures made to you, uses or disclosures pursuant to your authorization, disclosures made to HHS or its OCR for enforcement purposes, uses or disclosures that are required by law, and uses or disclosures that are required for this Plan's compliance with HIPAA's Administration Simplification Rules.

The Fund may not use or disclose your genetic information for underwriting purposes. The Fund may not sell or disclose your PHI for marketing purposes unless you provide a written authorization to do so. You may revoke such authorization at any time.

7. Miscellaneous

This Plan may disclose de-identified health information. Health information is considered de-identified if it does not identify you and there is no reasonable basis to believe the information can be used to identify you, such as your name and Social Security Number.

This Plan may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is PHI, which includes claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.

This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages it use or purchase. However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.

8. Duties of the Board of Trustees With Respect to PHI

This Plan will also disclose PHI to the Board of Trustees for Plan administration purposes. The Trustees have amended this Plan and signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents can be obtained from the Administration Office.

9. Complaints

If you believe your privacy rights have been violated, you may file a complaint with the Fund Administrator or the Board of Trustees. All complaints must be in writing and sent to the privacy officer at the address listed below. We may not retaliate against you or penalize you for filing a complaint.

Paula Dunning HIPAA Compliance/Privacy Officer
BeneSys, Inc.
700 Tower Drive, Troy MI 78098
(248) 813-9800 (telephone)

This notice is subject to change from time to time in order to comply with federal regulations. Whenever a material change is made, you will promptly be notified.

SELF-FUNDED MEDICAL PPO PLANS

Special Notices and Provisions of the PPO Medical Plans:

Newborns' And Mothers' Health Protection Act

Under Federal law, group health plans and health insurance issuers generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following normal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act of 1998

Medical and surgical benefits provided by the group health plan in connection with a mastectomy, must provide benefits for certain reconstructive surgery. In the case of a Participant or beneficiary who is receiving benefits under the plan in connection with a mastectomy and who elects breast reconstruction, the law requires coverage in a manner determined in consultation with the attending Physician and the patient, for:

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

Preferred Provider Option (PPO)

The PPO medical plans contain a Preferred Provider Option (PPO) where the Fund has contracted with a network of Hospitals and professionals to obtain services at reduced rates. Anthem Blue Cross is the preferred provider system for the Health Fund's self-funded medical plans. If you are traveling or reside outside of California, you will be using the BlueCard program. BlueCard is a program that allows Trust members to obtain access to PPO providers while traveling or living in a Blue Plan service area outside of California. You should contact the Fund Administrator if you have any questions about out of area providers.

The Network

The San Diego UNITE-HERE Health Fund has contracted with Anthem Blue Cross to address the problem of escalating health care costs. Anthem Blue Cross has an excellent network of Physicians and Hospitals in San Diego County, throughout California and in other states. These "preferred providers" (also called network providers) have agreed to provide services to you at rates significantly lower than their regular charges. The network includes Physicians in all medical specialties and most of the major Hospitals in the county including numerous hospitals and doctors in the San Diego and Imperial counties.

Preventive Health Benefits – PROVIDED BY A PPO PROVIDER ONLY

Preventive health benefits will be paid at 100% for recommended preventive services, as defined by federal law, provided by a PPO provider. The Plan will pay 100% of the cost of certain services provided by PPO provider if the services are preventive services recommended under guidelines published by the U.S. Preventive Services Task Force, the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention and the Health Resources and Services Administration (the Guidelines).

The preventive care benefits listed in the Guidelines can be found at **https://www.healthcare.gov/preventive-care-benefits.** As new or updated preventive care recommendations or Guidelines are issued, the Plan will have one year to implement the new Guidelines.

Medical benefits will be provided under the PPO Medical Plans and prescription benefits will be provided under the Sav-Rx drug program.

When provided by a PPO provider, all preventive services recommended by the Guidelines will be paid by the Plan without deductibles, co-pays or coinsurance.

If a recommended preventive care benefit or item is billed separately from an office visit, then cost-sharing may be applied to the office visit. If a recommended preventive care item or service is not billed separately from an office visit and the primary purpose for the visit is preventive care, then cost-sharing requirements may not be imposed with respect to the office visit. If a recommended preventive item or service is not billed separately from an office visit and the primary purpose of the office visit is not preventive care, then cost-sharing may be applied to the office visit.

Recommended Second Surgical Opinion

If any of the surgical procedures listed in the Second Surgical Opinion list are recommended by your Physician, the following will apply:

1. If a second opinion is obtained, the deductible will be waived for the first $200 in second opinion charges and this first $200 will be paid at 100%.

2. If a second opinion is not obtained, normal plan benefits will be calculated and then reduced by 20%. This reduction applies to all related Hospital, surgical, and medical charges.

3. If the second opinion does not confirm the initial diagnosis, benefits will be paid for a third opinion. If a Physician who gives a second or third opinion later performs the surgery, the increased benefit will not apply to the surgical opinion for that Physician.

4. Surgical opinion charges include only:

    - The charge for the professional services of a Physician; and
    - The charge for a laboratory test or x-ray examination that does not duplicate a prior test or examination

List of Recommended Second Surgical Opinions

Adenoidectomy	Hysterectomy
Back or Disk Surgery	Knee Surgery
Bunionectomy	Mastectomy
Cataract Surgery	Prostatectomy
Gall Bladder Surgery	Rhinoplasty
Hernia Surgery	Tonsillectomy

Whom to Contact for a Second Surgical Opinion

You may use any physician who specializes in the surgical procedure recommended. Your physician may provide you with a referral.

Pre-Admission Testing

Covered Medical Expenses include charges for pre-admission testing. Pre- admission testing applies only to laboratory tests and X-ray examinations that are required for surgery and performed on an outpatient basis within the ten-day period preceding the covered Participant's scheduled admission to an acute-care Hospital for surgery.

Covered medical charges for pre-admission testing will not be subject to a deductible. The percentage payable for these covered medical charges will be 100% - in place of any lower percentage payable that might otherwise apply.

Home Health Care Benefit

Deductible	$50 per calendar year
Percentage payable	As shown in the Schedule of Benefits

Diabetic Self-Management Training Program

Participants enrolled in the self-funded fee-for-service medical plans are eligible for participation in a diabetic self-management training program. Covered expenses include the charges incurred or a diabetic self-management training program that teaches a Participant and his Family Unit about:

1. The diabetic disease process; and

2. The daily therapies for control of diabetes which will help avoid complications and frequent confinements in a Hospital

No more than $100 will be paid for all charges incurred for the training program during a Participant's lifetime. No benefits will be paid for a program whose main purpose is weight reduction.

Smoking Cessation Program

Participants enrolled in the self-funded fee-for-service plan who need assistance with quitting smoking can take advantage of a smoking cessation program. The program must be offered through the American Lung Association, the American Cancer Society, or by a licensed Hospital (as defined in the Definitions section on page 108). Coverage includes treatment through hypnosis or acupuncture*, if administered by a provider who is licensed to render such services and a portion of his or her practice is dedicated to smoking cessation and/or withdrawal from nicotine.

Prescriptions and supplies are covered if they are only available by written Prescription of an appropriately licensed Physician, and dispensed by a Pharmacist.

*Acupuncture treatment for smoking cessation does not apply toward the maximums for acupuncture listed in the Schedule for treatment of other conditions.

Extended Benefits –PPO Medical Plans Only

If you or one of your Dependents is Totally Disabled at the time your coverage under this Plan terminates, benefits may be extended for expenses incurred due to that disability, if the following conditions are met:

1. The expense would have been covered if the benefits had continued; and

2. You or your Dependent remain disabled on the date such expense is incurred; and

3. You or your Dependent are not entitled to similar benefits under any other group plan, when each expense is incurred.

Medical benefits will be extended and payable after coverage terminates, but only for treatment of the Illness or injury that caused the disability. Benefits will be payable subject to the limitations and maximums that were in effect under the Plan at the time coverage terminated. Benefits will continue until the earliest of:

1. The date you or your Dependent are no longer disabled;

2. The date you or your Dependent become covered under another benefit plan which provides similar expenses;

3. 12 months from the date your coverage terminates.

A person shall only be entitled to receive extended benefits for a maximum of 12 months for any specific type of disability or Illness. If a person exhausts his or her 12-month extension of benefits as a result of a specific disability or Illness, that person will not be entitled to any extended benefits during a period of subsequent disability arising out of the same disability or Illness.

DESCRIPTION OF GENERAL PPO MEDICAL PLAN PROVISIONS

Listed below are the medical charges eligible for payment when incurred by a Participant covered by one of the self-funded PPO medical plans, and the payments for which you may be responsible. Benefit payments will be based upon the percentages payable and maximums shown in the Schedule of Benefits on pages 3 through 7 at the front of this booklet.

Co-Payment

As shown in the Schedule of Benefits, a fixed amount the participant must pay for a covered service, not subject to the deductible or a Percentage Payable.

Common Accident

If you and your Dependents incur covered medical charges as a result of injuries suffered in a common accident, just one deductible will apply during the calendar year of those charges. If greater medical benefits would be paid in the absence of this provision, then it will not apply.

Family Deductible Maximum

Once the family maximum deductible has been satisfied for the calendar year, no further deductible will apply to family members for the balance of the calendar year.

Deductible Carry-Over

If a covered Participant incurs charges during the last three months of a calendar year that are applied toward satisfaction of the medical deductible, those charges will also be applied toward their medical deductible for the next calendar year.

Percentage Payable

Each percentage payable and the charges to which it applies are shown in the Schedule of Benefits. A percentage payable:

1. Is applied after any deductible amount has been met; and

2. Applies separately to each covered Participant.

Calendar Year Out-of-Pocket Maximum

The out-of-pocket maximum per calendar year when using an Anthem Blue Cross network provider is limited to the amount shown in the Schedule of Benefits. When the maximum is reached, the Plan will continue to pay Covered PPO Charges at 100% of the allowed amount for the balance of the calendar year, subject to all other maximums, copayments, deductibles, and exclusions and limitations. ***There is no calendar year out-of-pocket maximum when using non-PPO providers.***

Covered Charges Limits

The "covered charges limits" that apply to each service or supply are:

1. The Network negotiated rates when network providers are used; as well when non-network (non-PPO) providers are used. Plan payments for Non-PPO providers based on the Anthem Blue Cross allowances for PPO providers providing similar services within a reasonable geographic location.

2. Charges that are Medically Necessary; and

3. Any limit specified in the Covered Medical Charges list or in the Areas of Limited Coverage section.

Medically Necessary

The term "Medically Necessary," with respect to each service or supply, means the service or supply meets all of the tests listed below:

1. It is rendered for the treatment or diagnosis of an injury or disease, including premature birth; congenital defect; and birth defects.

2. It is appropriate for the symptoms, consistent with the diagnosis, and is otherwise in accordance with generally accepted medical practice and professionally recognized standards.

3. It is not mainly for the convenience of the covered Participant or of the covered Participant's Physician or other provider.

4. It is the most appropriate supply or level of service needed to provide safe and adequate care and that satisfies the following requirements:

    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, service, supply, drug, medicine or equipment are clinically significant. The evidence also must demonstrate that there is a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than possible alternatives; and
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable; and
    c. For Hospital stays, acute care as an inpatient is necessary due to the kind of service the patient is receiving, the severity of the medical condition, and
    d. That safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Covered Medical Charges

1. The room and board charge of an acute care Hospital for each day a covered Participant is an inpatient. The covered medical charge for room and board for each day of confinement shall not be more than:

   a. The routine care daily limit for each day the covered Participant is an inpatient in a routine care unit
   b. The intensive care daily limit for each day the covered Participant is an inpatient in an intensive care unit
   c. The routine care daily limit for each day the covered Participant is an inpatient in a special care unit other than an intensive care unit. Routine Care and Intensive Care Daily Limits are shown in the Schedule of Benefits

2. The charges for an acute care Hospital, other than room and board charges, for medical services and supplies furnished on an outpatient basis.

3. The charges of a Skilled Nursing Facility for the confinement of a covered Participant as an inpatient, but only if the confinement:

   a. Follows a stay of at least five days as an inpatient in an acute care Hospital; and

   b. Starts within seven days after the covered Participant is discharged from that Hospital stay, Benefits for confinement in a Skilled Nursing Facility shall be payable for a maximum of 60 days for any one disability.

4. The charges of a rehabilitation Hospital for the confinement of a covered Participant as an inpatient, but only if the confinement:

   a. Follows a stay of at least three days as an inpatient in an acute care Hospital; and
   b. Starts within seven days after discharge from that Hospital stay. The covered medical charge for room and board for each day of confinement shall not be more that the rehabilitation Hospital daily limit shown in the Schedule of Benefits.

5. The charges of rehabilitation Hospital for medical services and supplies furnished on an outpatient basis.

6. The charges for medical services and supplies furnished by a specialized facility that is recognized in the Specialized Care Center definition. If the specialized facility provides inpatient care, the covered medical charge for room and board for each day a covered Participant is an inpatient shall not be more than the specialized facility daily limit shown in the Schedule of Benefits.

7. The charge of a Physician for the following professional services:

   a. Office visits, visits in an acute Hospital, at the patient's home, or at any other place, but not for more than one visit per day;
   b. Surgery, based upon network negotiated allowances or if a non-network provider is used, up to the covered charge limit determined from the applicable Relative Value Schedule and subject to the Surgery Guidelines shown below;
   c. Radiation treatment; and
   d. Anesthesiology, up to the covered charge limit determined from the applicable Relative Value Schedule and subject to the following Surgery Guidelines.

8. Surgery Guidelines

   a. If two or more surgical procedures are performed at the same time, the covered medical charges will be limited to those incurred for the major procedure, plus 50% of the charges incurred for each lesser procedure that adds significant time or complexity;
   b. The benefit for performing surgery includes normal follow-up care and the administration of any local, digital block, or topical anesthesia; and
   c. Reduced benefits may be paid for the administration of other anesthetics if done by the operating or assisting surgeon."

9. The charge of a Physician or laboratory for tests or an x-ray examination.

10. Charges for surgical sterilization.

11. Preventive Health Benefits

12. Except as specifically provided, charges incurred for the treatment of osteoporosis. Covered expenses will include all Food and Drug Administration (FDA) approved technologies, including bone mass measurement technologies as deemed medically appropriate by a Doctor.

13. Except as specifically provided the charge of a Physician for casts, splints, surgical dressings, and other medical supplies.

14. The charge for the professional services of a Nurse for private duty nursing.

15. The charges for medical services and supplies furnished by an Allied Health Professional who is recognized in the Allied Health Professional definition, but only if and to the extent that the charges would be covered if they were made by a Physician. Medical benefits for these charges will be determined on the same basis as medical benefits are determined for the charges of a Physician.

16. The charge for professional ambulance service to or from a local acute care Hospital or Skilled Nursing Facility where treatment is rendered, including air ambulance if medically necessary;

17. The charges for the following orthopedic or prosthetic appliances:

    a. Initial and subsequent post-mastectomy prosthetic devices or reconstructive surgery to restore and achieve symmetry for the patient, incident to the mastectomy;
    b. Artificial limbs or eyes and their Medically Necessary replacement; and
    c. Trusses, braces and supports.

18. The charge to rent or to buy durable medical equipment, but not to replace or repair such equipment.

19. The charge for oxygen, blood, blood products, anesthetics, or other medical supplies that can be lawfully obtained only with the prescription of a Physician.

20. The charge for a Drug or medicine that can be lawfully obtained only with the written prescription of a Physician or Dentist.

21. The charge of an acute Hospital for routine Nursery care furnished to a newborn well-baby while the mother is an inpatient.

22. Except as specifically provided, the charges for diabetic self-management training programs include charges incurred for teaching patients and their Family Unit about:

    a. The diabetic therapy for control of diabetes which will help the Participant avoid complications and frequent Hospital confinements.
    b. The daily therapy for control of diabetes which will help the Participant avoid complications and frequent Hospital confinements.

    The Fund will not pay more than $100 for all charges incurred for training programs during a patient's lifetime. No benefits will be paid for a program whose main purpose is weight reduction.

23. The charges for a second surgical opinion when rendered in accordance with the Plan. The deductible is waived for the first $200 of these charges, which are payable at 100%.

24. Charges for treatment of substance abuse, but only as described under the Schedule of Benefits.

25. Charges for treatment of mental and nervous conditions, but only as described under the Schedule of Benefits.

26. The charges for an outpatient smoking cessation program will be covered under the Plan when offered through the American Lung Association, the American Cancer Society, or under the auspices of any licensed Hospital Charges are subject to deductible and coinsurance provisions.

27. Hypnosis and acupuncture will also be covered under the Plan if such services are rendered by a licensed provider who has a portion of his or her practice devoted to smoking cessation and/or nicotine withdrawal. Acupuncture treatment for smoking will not accumulate toward the $750 and 40 visit maximums in the Schedule of Benefits for acupuncture treatment for other conditions.

28. Charges incurred for prosthetic devices to restore a method of speaking incident to a laryngectomy. Covered Medical Expenses will include the initial and subsequent prosthetic devices or installation accessories, as ordered by your Doctor, but will not include electronic voice producing machines.

29. For services provided by a non-PPO provider; charges for one complete annual physical examination in each calendar year for eligible Active Employees only, including related X-rays and lab work, but not X-rays and lab work related to a diagnosed or suspected medical problem.

    For men, a routine physical examination will be covered up to $135 without a Prostate Specific Antigen (PSA) test. For women, a routine physical examination will be covered up to $135.

30. Pregnancy Benefits

    For female Employees and Dependent wives of Employees benefits will be paid or the covered medical charges incurred for treatment of pregnancy on the same basis as medical benefits are paid for treatment of an illness.

    For Dependent daughters of Employees benefits will be paid for the covered medical charges incurred for treatment of a Complication of Pregnancy on the same basis as medical benefits are paid for treatment of an illness. No other charges incurred by a Dependent daughter in connection with pregnancy are covered by the Plan, except for pre-natal care covered under preventive services.

31. Coverage for eligible expenses from clinical trials
    a. The following items and services in connection with a Clinical Trial will also be deemed Covered Medical Charges under the Plan:
        1) Physician fees, laboratory expenses, and expenses associated with a hospitalization;

2) The costs of evaluation and treatment of the Participant or Dependent associated with the underlying condition;
3) The costs of care consistent with the usual standards of care whenever a Participant or Dependent receives medical care associated with an approved clinical trial; and
4) The costs of any other care that would be covered by the Plan if such items and services were provided other than in connection with an approved Clinical Trial.

b. The following items and services in connection with a Clinical Trial **shall <u>not</u> be deemed Covered Medical Charges** and thus shall not be covered by the Plan**:**
1) The costs of the investigational drugs, devices or services that are the subject of the Clinical Trial;
2) The costs of any non-health services that might be required for a Participant or Dependent to receive the clinical trial treatment or intervention (e.g., transportation, hotel, meals and other travel expenses);
3) The costs of managing the Clinical Trial research; or
4) The costs of any items or services that would not be covered under the Plan for non- investigational treatments.

However, routine costs associated with certain "approved clinical trials" related to cancer or other life-threatening illnesses covered to the extent required under the ACA. Clinical Trial means items and services in connection with a scientific study of a new therapy or intervention for the treatment, palliation, or prevention of cancer or other life threatening illness that meets all of the following requirements:

a. The treatment or intervention is provided pursuant to an approved clinical trial for cancer or other life threatening illness that has been funded authorized or approved by one of the following:
1) The National Institutes of Health (NIH) including the National Cancer Institute (NCI);
2) The United States Food and Drug Administration (FDA) in the form of an investigational new drug (IND) exemption;
3) The United States Department of Veteran Affairs (VA);
4) Centers for Disease Control and Prevention (CDC);
5) Agency for Healthcare Research and Quality (AHRQ); or
6) Centers for Medicare and Medicaid Services (CMS).

b. The proposed therapy or intervention has been reviewed and approved by the applicable qualified Institutional Review Board.

c. The available clinical or pre-clinical data indicate that the treatment or intervention provided pursuant to the approved clinical trial will be at least as effective as standard therapy, if such therapy exists, and is anticipated to constitute an improvement in effectiveness for treatment, prevention, or palliation of cancer or other life threatening illness.

d. The facility and personnel providing the treatment are capable of doing so by virtue of their experience and training.

e. The trial consists of a scientific plan of treatment that included specific goals, a

rationale and background for the plan, criteria for patient selection, specific directions for administering therapy and monitoring patients, a definition of the quantitative measures for determining treatment response, and methods for documenting and treating adverse reactions. All such trials must have undergone a review for scientific content and validity, as evidenced by approval from one of the federal entities identified above.

f. The trial must:
   1) Evaluate a service which is otherwise a Covered Medical Charge; and
   2) Have a therapeutic intent (i.e., not designed exclusively to test toxicity or disease pathophysiology); and
   3) Enroll diagnosed Participant or Dependent.

Areas of Limited Coverage

The following limits apply to all outpatient treatment received by a Participant during any one calendar year for acupuncture:

1. Covered medical charges include the expenses incurred for up to 40 outpatient treatments during any one calendar year; and
2. Benefits of no more than $750 will be paid for all outpatient acupuncture treatments received by the Participant during any one calendar year.

Substance Use Disorder

Covered medical charges for the treatment of substance use disorder.

Anesthesia

The Anesthesia Basic Value includes payment for pre- and post-operative visits, the administration of anesthetic, fluids, and/or blood incident to the anesthesia or surgery.

When a pump oxygenator with or without hypothermia, is employed with anesthetic, the Anesthesia Basic Value will be increased by 10.0. No payment will be made for local infiltration anesthesia administered by the surgeon or assisting Physician.

"T" Time units are computed by allowing a Relative Value of 1.0 for each 15 minutes of anesthesia time. Anesthesia time starts with the beginning of the administration of the anesthetic agents and ends when the anesthesiologist is no longer in personal attendance (when the patient may be safely placed under customary post-operative supervision).
Anesthesia Basic Value + Time Unites = Total Anesthesia Payment

Assisting Physician

The allowance for an assisting Physician for a surgical procedure is the greater of:

1. A Relative Value of 1.7; or
2. 20% of the procedure performed.

Facility Charges

The facility charges for care furnished in an acute care Hospital, or specialized facility, are covered medical charges for room and board for each day of confinement and is subject to the limits stated in the Covered Medical Charges lists.

Inpatient Charges

Facility, practitioner, and medical support charges incurred for the inpatient treatment.

Outpatient Charges

Facility, practitioner, and medical support charges incurred for the outpatient treatment.

Practitioner Charges

Practitioner charges for inpatient and outpatient visits to a Physician or Allied Health Professional are covered medical charges

Psychiatric Treatment

Covered Charges for psychiatric treatment.

Home Health Care Benefit

This plan covers the Home Health Care percentage payable amount of covered home health charges incurred in excess of the Home Health Care deductible during a calendar year. The Home Health Care deductible and percentage payable are shown in the Schedule of Benefits.

Covered Home Health Care Charges

The charges for home health care that are listed below are covered by this Plan. Benefits will not be payable for Home Health Care unless the Home Health Care plan is drawn up, or approved, by the covered Participant's Physician. The program must be for the same or related disability for which the Participant was hospitalized. The Physician must also certify that:

1. Home Health Care is Medically Necessary; and

2. In the absence of Home Health Care, the covered Participant would be an inpatient at an acute care Hospital, rehabilitation Hospital, or Skilled Nursing Facility. Home Health Care charges include only the charges for the following medical services and supplies furnished on a visiting basis in a private residence (not necessarily the Participant's residence) for treatment of a covered Participant's bodily injury or disease:

3. The charge for the services of a home health aide on a part-time or intermittent basis.

4. The charge for the professional services of a registered Nurse (RN), a licensed practical Nurse (LPN), or a licensed vocational Nurse (LVN) on a part-time or intermittent basis.

5. The charge for physical, occupational, speech, respiratory or rehabilitation therapy.

6. The charge to rent (not to exceed the purchase price) or buy durable medical equipment, but not the repair or replacement of such equipment.

7. The charge for laboratory services, medical supplies, oxygen, Drugs and medicines prescribed by a Physician – to the extent that such charge would have been covered under the Plan if the Participant had been a registered inpatient at a Hospital when the charge was incurred.

Home Health Care Excluded Charges

Covered Charges do not include any charge for:

1. Housekeeping services, maid services, or any personal services which are not actual medical treatment, except for personal services which can be shown to be essential to the medical treatment of the Participant; or
2. Any service or supply that would be excluded if the insured were confined as an inpatient in a Hospital or Convalescent Hospital.

Hospice Care Benefit

The charges for Hospice Care that are listed below and meet the Covered Medical Expenses definition are covered. Benefits will be paid for Hospice Care charges incurred only during a period validated by a Physician's certification that the Participant is a terminally ill patient.

No benefit will be payable for:

1. More than the Hospice maximum shown in the Schedule of Benefits for all Hospice Care charges incurred either by the Terminally ill patient or their Family Unit, before the patient's death; or

2. More than $100 for covered Hospice room and board charges per day.

Special Benefit Limits

The following special benefit limits apply to Hospice Care:

1. There are no deductibles.

2. The Plan covers 90% of Covered Charges (75% of Covered Charges under the Blue Basic PPO Medical Plan) when services are received from a network provider and 50% of Covered Charges when services are received from a non- network provider.

3. The limits specified in the Covered Charges list and in the Areas of Limited Coverage section do not apply to:

   Hospice Care charges include:

   a. The charges made by a Hospice for the confinement of a terminally ill patient as an inpatient.
   b. The charges for Home Health Care furnished to the terminally ill patient in the patient's home.
   c. The charge for the services of a home health aide.
   d. The charge for the professional services of a Nurse.
   e. The charge for physical therapy, speech therapy, or occupational therapy.
   f. The charge for nutrition counseling and special meals.
   g. The charge for Medical Social Services furnished to the terminally ill patient or their Family Unit.
   h. The charge made by an Interdisciplinary team for services rendered.
   i. The charge for Prescription Drugs, medications, or other biologicals of a palliative nature when prescribed by a Physician for pain."

Covered Medical Charges – Hospice

For Hospice Care only, the terms of the Comprehensive Medical Benefits are changed as follows, so that Hospice Care charges meet the tests of the Covered Medical Charges definition.

1. The General Health Limitation that excludes benefits for custodial care does not apply.

2. The definition of "Medically Necessary" (see page 109) includes:

    a. Medical Social Services, and is changed as follows:

        i. Test 1 is changed to include Palliative Care, as well as treatment or diagnosis, and
        ii. Test 4 is changed to allow inpatient respite care.

GENERAL HEALTH COVERAGE EXCLUSIONS AND LIMITATIONS

The General Health Limitations apply to all benefits other than any Life Insurance coverage under the Plan, except:

1. Section B of the Excluded Charges list does not apply to any AD&D coverage; and

2. Section C of the Excluded Charges list applies only to medical coverage under the group Plan.

Excluded Charges

Section A – No benefit will be paid for, or in connection with, any injury or disease:

1. Resulting from or arising out of any past or present employment or occupation for compensation or profit;

2. Resulting from any act of war;

3. The covered Participant's commission of a crime (unless such injury or illness is the result of domestic violence against the participant, or the commission or attempted commission of a crime is the direct result of an underlying health factor); or

4. Non-therapeutic release of nuclear energy.

Section B – No benefit will be paid for, or in connection with, any;

1. Charge, or part of a charge, the covered Participant is not obligated to pay or for which the covered Participant would not have been billed except for the fact that they were covered under this Plan;

2. Service that is rendered by a person who ordinarily lives in the covered Participant's home;

3. By a spouse, child, parent, or sibling of the covered Participant or the covered Participant's spouse; or

4. Experimental treatment.

Section C – No benefit will be paid by the medical Plan for, or in connection with, any:

1. Service or supply that is for experimental procedures or investigative therapy in accordance with the American Medical Association's Diagnostic and Therapeutic Technology Assessment Program and/or in conjunction with independent medical consultant opinion except clinical trials as noted on pages 50 through 52.

2. Service or supply that is not prescribed by a Physician or an Allied Health Professional who is practicing within the scope of their license;

3. Custodial care, regardless of who prescribes or renders such care;

4. Eye refractions, glasses, contact lenses, or the fitting of glasses or contact lenses, except for the first pair of glasses or first pair of lenses for use after cataract surgery;

5. Reversal of sterilization, unless Medically Necessary;

6. Procedure performed mainly to improve the appearance of the covered Participant –except for cosmetic surgery to repair damage sustained in an Accident that occurred while the Participant's coverage was in force under this Plan and the charges are incurred while the Participant is covered under the Plan and within two years from the date of the Accident; or unless it is reconstructive surgery for repair of a congenital disease or abnormality of a covered Participant;

7. Service or supply to diagnose, treat, repair or replace the teeth, gums or supporting structure of the teeth unless it is rendered for repair of damage to sound natural teeth if the damage is sustained in an Accident, the Participant is covered under the Plan and the charges are incurred within two years from the date of the Accident. Sound natural teeth means teeth that are organic and formed by the natural development of the body (not manufactured), have not been extensively restored; and

8. Radial keratotomy or any other surgical procedure to treat a refractive error of the eye, unless visual acuity cannot be improved to at least 20/70 in the better eye by the use of any lens;

9. Treatment of infertility, including;

    a. Artificial insemination
    b. In vitro fertilization or other procedures involving the eggs and sperm;
    c. Implantation of an embryo developed in vitro;
    d. Drug therapy;
    e. Ovulation induction therapy; and

f. Monitoring laboratory, radiological and ultrasound studies – this limitation will not exclude diagnostic testing to determine the cause of the infertility.

10. Gene Therapy. An expense for or related to gene therapy or CAR-T gene therapy, which are types of therapy that seeks to modify or manipulate the expression of a gene or to alter the biological properties of living cells for therapeutic use, including, but not limited to, Zolgensma, Kymriah, Luxturna and Yescarta, and any expense for a prescription drug, laboratory test, hospital, physician visit or other service or treatment for or related to gene therapy.

PRESCRIPTION DRUG COVERAGE

FOR PARTICIPANTS ENROLLED IN ONE OF THE SELF-FUNDED MEDICAL PPO PLANS

The Prescription Drug benefits in this section are provided through a contract with Sav-Rx for persons enrolled in the self-funded Medical PPO plans. Refer to pages 8 through 10 for a description of the member copayments.

Maximum Out of Pocket Maximum

After individual out of pocket expenses for eligible PPO medical and prescription drug expenses reach $6,350 ($12,700 family) in a calendar year, the Plan will pay 100% of covered expenses for the remainder of the calendar year.

Out-of-Pocket expenses for Prescription Drugs will not include expenses for drugs not covered under the Plan or financial penalties imposed for non-compliance with the step therapy or generic substitution features of the program.

What is Covered?

The following Drugs are covered by the Plan:

Drugs that:

- can only be obtained by Prescription as required by state and federal law;
- Have been approved by the Food and Drug Administration (FDA) for general marketing; and
- Are dispensed by a licensed Pharmacist and are prescribed for the Participant's use by a Physician,

Covered drugs also include insulin, insulin syringes and chemical strips and drugs that are required to be covered without member copayments under Preventive Health benefits described on pages 41 through 42.

Prior Authorization and Step-Therapy Requirements:
Please call (800) 228-3108 for prior authorization and step-therapy drug information

Prior Authorization: Prior authorization will be required on all specialty medications and will be limited to a maximum fill of 30 days through the Sav-Rx Specialty Pharmacy only.

Step-Therapy: The trial and failure of at least one generic for the following therapeutic classes is required before other prescriptions are covered: Statins, SSRI Antidepressants, ARB/ACE (blood pressure), Sleep Aids and Proton Pump Inhibitors.

SPECIALTY DRUG: All specialty drugs are required to be obtained through the Sav-Rx Specialty Pharmacy by mail order for up to a 30-day supply for each prescription fill or refill. If the specialty drug you are using is part of the High Impact Advocacy Program, you will be required to enroll in this program. Sav-Rx will assist you with your enrollment into the High Impact Advocacy program, which is a manufacturer-sponsored coupon program. If you have any questions regarding the Sav-Rx Specialty Pharmacy, please call (800) 228-3108.

How Does the Program Work?

Present your Prescription Drug Program ID card to the participating pharmacy when obtaining your Prescription. If your name is included in the list of those participants eligible for coverage under this Plan, you will pay applicable copayment and the participating pharmacy will bill and receive payment directly from the Health Fund.

You may either go to a participating pharmacy to fill your Prescriptions (Walk-In Program) or fill your Prescription through the mail (Mail-Order Program). The copayments are the same for prescriptions obtained through a local walk-in pharmacy or through the mail order program. However, prescriptions filled at the local pharmacy require a separate copayment for each 30-day supply but through mail order, you can obtain a 90-day supply for one copayment.

Walk-In Prescription Drug Program

When you use this Plan option, you may go to any participating pharmacy to fill your Prescription. If you use a network pharmacy, you will be required to pay the applicable copayment per Prescription.

If you obtain Prescription Drugs at a non-network pharmacy, you will have to pay the full charge of the Drug and then file a claim with the Sav-Rx office for reimbursement. The Plan will reimburse 60% of the average amount allowed for a prescription drug in a geographic area based on the Sav-Rx average contract discounts, less the applicable co-payment.

You can obtain a list of network pharmacies from the Trust office or by calling (800) 228-3108 Or by logging on to the website at www.savrx.com.

When you fill a Prescription, a generic Drug (if available) will automatically be substituted for a brand-name Drug, unless you or your Physician specifically indicates otherwise. Generic Drugs are equal to brand-name Drugs in chemical composition and active ingredients, however, because of patent laws, generic Drugs are identified by their chemical name. Generics have the

same affect and meet the same federal government standards as their brand-name equivalents, but they are less expensive.

When a Prescription is written that allows for a refill (or refills), you may receive one Prescription only. Subsequent refills will be provided no sooner than five days prior to the exhaustion of the previous Prescription supply. For example, if your Prescription is for a 30-day supply, a refill is allowed after 25 days have elapsed. Likewise, a 15-day supply would be refillable after ten days have elapsed.

Mail-Order Prescription Drug Program

Sav-Rx has a convenient mail-order program that is an inexpensive way for you to order up to a 90-day supply of any covered Prescription Drug (not just maintenance medication) for direct delivery to your home. The copayments for Drugs purchased through the mail-order program are shown in the schedule. Only one copayment is required for a 90-day supply.

What is Maintenance Medication?

Maintenance medications are Drugs taken regularly on a long-term basis. A few examples of maintenance medications are those taken for high blood pressure, arthritis, heart conditions, ulcers, diabetes, etc.

Advantage of the Mail-Order Program

You can save money and time by using the Mail-Order Program: Order up to a 90-day supply of medication, and pay the same copayment amount for a 30-day supply as you would at a walk-in pharmacy. Your medications are conveniently delivered to your home via U.S. Mail or UPS. Additionally, since you can receive up to a 90-day supply, you will be spared the bother of frequent re-orders.

How to Use the Mail-Order Program

1. Ask your Doctor to prescribe needed medications for up to a 90-day supply, plus refills.
   Complete the customer information (initial order form) with your first order only. Be sure to answer all the questions for yourself and your Dependents. The order form may be requested from the Fund Administrative Office or Sav-Rx at (800) 228-3108 or on the internet at www.savrx.com.

2. Send the completed order form and your original Prescription(s) to Sav-Rx. Enclose the appropriate copayment with your Prescription.

3. Sav-Rx will process your order within 24 hours of receipt and send your medications to your home by first class U.S. Mail, with instructions for future Prescriptions and/or refills.

Exclusions

The following Drugs and supplies are not covered under the Prescription Drug Benefit:

1. Drugs which are sold over-the-counter, or do not legally require a Physician's written Prescription, and Prescription equivalents sold over-the-counter. However, non-prescription (or non-legend or over-the-counter) drugs or medicines, except certain types of insulin and certain over-the-counter (OTC) medication prescribed by a Physician, are covered in accordance with ACA regulations.

2. Prescription Drugs which may be properly received without charge under local, state, or federal programs – including Workers' Compensation programs or Occupational Disease law.

3. Devices of any type, (with the exception of Ostomy supplies), even though they may require a Physician's Prescription.

4. Drugs prescribed for cosmetic purposes, including (but not limited to): Rogaine solutions; external preparations of Minoxidil and any mixtures or compounds containing Minoxidil; weight reducing Drugs; and Retin-A in all forms, except when prescribed for Acne Vulgaris.

5. Injectable Drugs other than insulin, glucagons and Imitrex unless approved in advance by Sav-Rx.

6. Hypodermic needles, syringes or similar devices used for any purpose other than the administration of insulin.

7. Prescriptions related to any non-covered services.

8. Prescriptions dispensed in a Physician's office.

9. Immunization agents, biologicals, blood or blood plasma.

10. Charges for the administration of any Drug.

11. Fertility Drugs, and all medications used for the treatment of infertility.

12. Experimental or investigational Drugs unless required to be covered as part of a Clinical Trial covered under the PPO Medical Plans.

13. Prescriptions dispensed by a Hospital during confinement.

14. Any items prescribed for purposes other than the treatment or diagnosis of a specific Illness or Accident.

15. Minocin.

16. Non-sedating antihistamines.

17. Vitamins, unless required under the Preventive Health benefits.

18. Growth hormones.

19. Weight-loss medications

20. Prescription drugs for the treatment of sexual dysfunction over six pills per month.

SELF-FUNDED FEE-FOR-SERVICE DENTAL BENEFITS

Participants may opt out of dental and vision (with no change in their premium). Contact the Fund Administrator for more information.

The self-funded fee-for-service dental plan is one of your options if you qualify for dental benefits. If you enroll in this plan, you will have the benefits described in this section.

Note: Retired Employees must elect and pay the entire cost for this coverage.

Dental coverage encourages you to practice preventive care and helps you pay your dental bills should a problem occur. Dental benefits are payable for covered dental charges incurred while you are covered by this plan, as determined below.

Dental services are available at the Family Health Center to all members and their families enrolled in the self-funded dental plan, regardless of your medical plan selection in either the Blue Select, Blue Plus, SIMNSA or Kaiser plans. However, participants enrolled in the Blue Basic plan have "member only" dental coverage when services are provided by the Family Health Center.

Dental Benefits and Covered Charges

Dental Deductible

The dental deductible of $50 per calendar year (waived for Preventive Services for those using Bonita Dental Office facilities):

1. Applies to all covered dental charges unless otherwise noted;

2. Applies separately to each Participant during each calendar year; and

3. Must be accumulated during the calendar year.

Only the charges where a deductible applies will be counted toward satisfying the dental deductible.

Deductible Carry-Over

If a Participant incurs charges during the last three months of a calendar year which are applied toward satisfying the dental deductible, those charges will also be applied toward that person's dental deductible for the next calendar year.

Dental Percentage Payable

Payable percentages are applied to the covered dental charges after any applicable deductible amount has been met.

Preventive Services… .....100% scheduled limit*
Basic Services .....80% scheduled limit*
Major Services… .....50% scheduled limit*

Those using Bonita Dental facilities will have 100% of the scheduled limit covered up to the annual maximums.

*The Plan has a set **schedule of benefits** which may be less than the amount your provider charges. You may contact the Fund Administrator to find out how much is payable for any covered procedure.

Implant treatment at the **Family Health Center** will be subject to maximum $800 co-payment.

The Trust also has a contract with **First Dental Health** that allows Participants to use the provider's Exclusive Provider Network of dentists. The maximum amount the dental office is allowed to charge is based on the amounts negotiated by First Dental Health and will change annually.

Dental Service Categories

Preventive Dentistry includes services and supplies for or in connection with prophylaxis, X-rays, examinations, and biopsies.

Major Dentistry includes Covered Dental Services and supplies for or in connection with partial or complete dentures or implants.

Basic Dentistry includes all other Covered Dental Services and supplies.

Dental Benefit Maximum

The maximum benefits payable for each employee and each covered dependent for services at Bonita Dental is $2,500 per employee and $2,500 per each covered dependent each calendar year. The maximum benefits payable for each employee and each covered dependent enrolled in the **Family Health Center** is $3,500 per employee and $3,500 per each covered dependent each calendar year. If you do not have dental service performed at Bonita Dental or Family Health Center benefits will not be payable for more than $2,000 per each employee each calendar year or a maximum of $1,500 per calendar year for each covered dependent.

Covered Dental Charges

A Dental charge is covered if:

- It is made by a Dentist or Dental Hygienist for a Covered Dental Service furnished to a Participant

- It is incurred by a Participant while insured by this dental plan. A charge is deemed to be incurred at the time the service is rendered for which the charge is made. The date a dental service is deemed to be rendered is shown in the Date Dental Service Rendered provision below.

- It is not excluded by Deferred Dental Coverage, Dental Exclusions, or the General Health Limitations provisions of this plan.

- It does not exceed the smallest of the covered charge limits that apply to the service for which the charge is made. The part of a charge that does not exceed the smallest of the covered charge limits shall be considered a covered dental charge if it meets all three tests above.

Covered Charge Limits

- Covered Charges will be paid according to the dental benefits in the Plan's Schedule of Allowances.

- When a service or supply has an appropriate alternative that is in accordance with accepted standards of dental practice, the service or supply having the lesser charge shall be considered the covered charge.

- The covered dental charges for a Program of Dental Treatment for which a Dental Treatment Plan is not submitted to the Fund Administrator shall be limited as stated in the Pre-Determination of Benefits provision.

Pre-Determination of Benefits

A pre-determination of benefits is required when a Dentist estimates the charges for a Program of Dental Treatment will be more than $1,000. "Pre-determination of benefits" means that before a Participant receives any such treatment, he or she must:

- Submit a Dental Treatment Plan, completed by the attending Dentist to the Fund Administrator (or submit the Plan to First Dental Health (FDH) if using an FDH provider), and

- Get the Plan's estimate of the dental benefits for the Program of Dental Treatment. This provision does not apply to charges for Emergency treatment.

If the required Dental Treatment Plan is not submitted, at its sole discretion, the Fund Administrator:

- May limit the amount it considers covered dental charges to $300, or the covered dental charges for the least expensive alternate procedures which will produce a result that meets professionally recognized standards; or

- In the absence of satisfactory dental proof, may deny the claim.

Date Dental Service Rendered

A Covered Dental Service is deemed to be rendered on the date shown below that applies to the service.

Dental Service	Date Deemed Rendered
Dentures or Partial Dentures	The date the master impression is taken, or the placement date.
Fixed Bridges, Crowns, Inlays, and Onlays	The date the teeth are first prepared, or the placement date
Root Canal Therapy	The date the pulp chamber is opened and canals explored to the apex.
All Other Services	The date the service is rendered, or a supply furnished.

Orthodontic Coverage for Dependent Children

Orthodontic coverage will be available for eligible Dependent children, 19 years of age and younger. A treatment program for Dependent Children who begins treatment at age 19 shall be limited to a maximum of two years. In order to qualify for coverage, the Employee must have been eligible for coverage at least 30 months of the 36 months immediately preceding the initial banding. If orthodontic treatment is provided at the **Family Health Center**, the co-pay will be maximum $600.00.

The Plan pays 70% of the initial banding. Monthly adjustments (if eligible during that month) and related X-rays, extractions and retainers are paid at 70% and are limited to:

- $2,000 lifetime maximum and payable to licensed Orthodontists in the United States or $3,500 for each Dependent enrolled in the Family Health Center; or
- $1,000 for services provided by an approved orthodontist in Mexico.

Benefits After Termination of Coverage

The only dental benefits that will be paid on behalf of Participants after their dental coverage ends shall be for covered dental charges incurred for treatment that:

- is rendered while the Participant is covered by the dental Plan as shown above; and
- is completed within 30 days of the date their dental coverage terminates.

Dental Proof

The written proof required by the Fund Administrator shall include the following items:

1. A complete dental chart that shows extractions, missing teeth, fillings, prostheses, periodontal pocket depths, orthodontic relationships, and the date of any previous treatment.
2. An itemized bill for all dental care.
3. X-rays and study models.
4. Laboratory and Hospital reports.

Out-of-Country Dental Services

Dental Services obtained out-of-country must be rendered by an approved Dentist. A list of approved Dentists in Mexico can be obtained by calling the Fund Administrator.

All benefits for out-of-country dental services will be paid at 50% of the Fund's Schedule of Allowances.

Dental Exclusions

No dental benefits will be paid for any charges excluded by the General Health Limitations, or for any of the items listed below:

1. Procedure that is not necessary, or does not meet professionally recognized standards.

2. Replacement of any of the following items within five years of the date it was installed:

    a. A bridge;
    b. A partial denture;
    c. A full denture;
    d. An inlay or
    e. A crown.

    An exception will be made to this exclusion if the replacement is made necessary by an injury to sound natural teeth, if the injury is sustained in an Accident.

3. Replacement of an existing prosthesis which, in the opinion of the attending Dentist, can be made satisfactory.

4. A procedure that is performed mainly to improve the appearance of the Participant. An exception will be made to this exclusion if the replacement is made necessary by an injury to sound natural teeth, if the injury is sustained in an Accident provided the replacement is completed within two years of the date of the injury.

5. Facing on a crown or on a plastic or composite restoration, when the crown or restoration is on a tooth behind the second bicuspid.

6. Replacement of an item that has been lost or stolen.

7. Orthodontia treatment, except for eligible Dependent children.

8. Appliances, except for occlusal orthodontic appliances, restorations, or procedures for the purpose of restoring or maintaining occlusion, splinting, or replacing tooth structure lost as a result of abrasion or attrition, or treatment of disturbances of the temporomandibular joint (TMJ).

9. Dietary planning, oral hygiene instruction, or training in preventive dental care.

10. Treatment of a congenital or developmental malformation.

11. Treatment of an injury resulting from war, whether declared or undeclared, or from any act of war.

12. Treatment of an injury arising out of or in the course of employment, or that is compensable under any Workers' Compensation law or Occupational Disease act or law. If a Participant is insured by both the dental and medical plans under the group Plan, and incurs charges that would be considered covered by both medical and dental coverage, the terms of each Plan will determine the benefits payable, if any. These benefits will be paid under the coverage that would pay the greater benefit.

Coverage Limits

1. Dental benefits are limited to two routine visits in a calendar year. These visits include oral examinations and routine prophylaxis (teeth cleaning).

2. Dental benefits are limited to one complete mouth survey X-ray during any period of three consecutive years.

3. Dental benefits are limited to one fluoride treatment during any twelve month period for Employees or Dependents who are under the age of 19.

4. Orthodontic lifetime maximum is limited to $2,000 for services provided in the United States and $1,000 in Mexico.

VISION CARE

Participants may opt out of dental and vision (with no change in their premium). Contact the Fund Administrator for more information.

The Vision benefits in this section are self-funded and provided through an administrative services contract with Vision Service Plan (VSP). Retired Employees are not eligible for this benefit.

Schedule of Vision Benefits	
Copayments – Examinations	$ 5 per Participant; routine retinal screening up to $39.
Materials	$15 per Participant
Frequency of Services – **Ex**aminations	Once every 12 months
Lenses (single vision, lined bifocals, lined trifocals)	One pair every 24 months
Frames	One set every 24 months
Contact Lenses (instead of glasses)	One pair every 24 months (in lieu of all other benefits
Elective	$130 allowance every 24 months (the maximum you will pay for a vision exam from a Member Doctor is $60)

Vision Benefits

The Vision plan provides the following benefits to eligible Employees and their qualified Dependents up to the maximums specified, when services are rendered by VSP Member Doctors:

1. Vision Examinations – A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities. Available every 12 months.

2. Lenses – The Member Doctor will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The Doctor also verifies the accuracy of the finished lenses. Available every 24 months.

3. Frames – The allowance for frames under this plan is $150.00. If you select a frame that costs more than the allowance you will receive a 20% discount on the overage. Available every 24 months.

3. Contact Lenses – Medically Necessary contact lenses are furnished under the Plan when the VSP Member Doctor secures prior approval for the following conditions:

   a. Following cataract surgery;
   b. To correct extreme visual acuity problems that cannot be corrected with spectacle lenses;
   c. Certain conditions of anisometropia; or
   d. Keratoconus

4. Diabetic EyeCare Plus Benefit- Patients may receive care from a Member Doctor for care related to diabetic eye disease, glaucoma or age-related macular degeneration. Patients can also receive preventive retinal screenings if they have diabetes but do not show signs of diabetic eye disease. There is a $20.00 co-pay.

When member Doctors receive approval for such cases, costs are covered in full by VSP, in lieu of all other material benefits – including spectacle lenses and frames.

Elective Contact Lenses: Patients may choose contact lenses in lieu of frames and lenses. Under this plan there is an allowance of $130 for contacts. This allowance applies to the cost of the contact lens exam and contacts. The maximum you will pay for a contact lens exam provided by a Member Doctor is $60.

Cost of Benefits

When you select a Doctor from the VSP list, this plan covers the visual care described herein (examination, professional services, lenses, frames) at no cost to you other than a $5 copayment for examinations (except contact lens exam), and a $15 copayment for materials. Copayments are payable to the Member Doctor at the time of the examination. Any additional care, service and/or cosmetic options/materials not covered by this Plan may be arranged between you and your Doctor.

How to Use the Plan

- Obtain a brochure from your benefits representative.
- Call a VSP Member Doctor to make an appointment. Advise them that you are a VSP member. To locate a VSP doctor go to www.vsp.com or call Member Services at (800) 877-7195.
- The VSP Member Doctor and VSP will handle the rest by verifying your eligibility and plan benefits.

- The VSP Member Doctor will perform the exam and, if necessary, prescribe and order materials.
- Pay copayment amount for covered services and any out-of-pocket expenses (if any) for optional and/or cosmetic options not covered by the Plan.
- VSP will pay the Doctor directly for covered services – no further paperwork is required of you.

How to Submit a Non-Member Doctor Claim

- When using an out-of-network provider you will be required to pay the provider in full at the time of service.
- To receive reimbursement, submit to VSP an itemized copy of the bill(s) from the non-member Doctor, along with your name, address, phone number, covered members ID number and the name of the organization your VSP coverage is through. Forward the information to:

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

- Claims must be submitted within 6 months from date of service. Please be aware that there is no guarantee that the reimbursement will be sufficient to cover the total cost of all charges.

Maximum Reimbursement Schedule
for Services Received from a Non-Member Provider

Copayments…..... $ 5.00 Exam
… ..... $15.00 Materials

Non-Member Provider Services

Vision examination, up to.....$45

Materials
Single vision lenses, up to…..... $45
Bifocal lenses, up to..... $65
Trifocal lenses, up to…..... $85
Lenticular lenses, up to… $125
Frames, up to…..... $47

Contact Lenses* (materials, fittings evaluation only)
Medically Necessary, up to…..... $210
Elective, up to… $105

**If you or a Dependent obtains contact lenses from a non-member provider, determination of "necessary" versus "elective" contract lenses will be consistent with member Doctor services. Reimbursement allowance for necessary and elective contact lenses includes: lens evaluation fee, fitting costs and materials, and is in lieu of all other material benefits (including spectacle lenses and frames).*

Customer Service

Customer service is available 24-hours a day by calling 1-800-877-7195. The web site is also available for plan information as well as your personal benefits at the address: www.vsp.com.

LIFE INSURANCE BENEFIT FOR EMPLOYEES AND RETIRED EMPLOYEES

The Life insurance benefits described in this section are fully insured with Union Labor Life Insurance Company. If you die from any cause while you are insured, the proceeds will be paid to your beneficiary. The amount of coverage on any Participant shall be determined in accordance with the Schedule of Benefits. Any increase or decrease in the amount of coverage shall become effective on the date of the Participant's change of classification.

Note: Retired Employees must elect and pay the entire cost of this coverage.

Beneficiary

You may name anyone you wish as your beneficiary. You may change your beneficiary at any time by completing the proper form. The change will be effective when the Fund Administrative Office receives the completed form. If you do not name a beneficiary, or if your named beneficiary dies before you, the proceeds will be payable to the first of the following:

1. Your spouse
2. Your children
3. Your parents
4. Your brothers and sisters
5. Your executors or administrators

$500 of your Life Insurance benefit may be payable to either your beneficiary, executor or administrator, spouse, any Relative by blood or marriage, or any person appearing to be equitably entitled to this benefit by reason of having incurred last Illness or burial expenses on your behalf.

Total Disability

If you are prevented from engaging in any occupation or employment for which you are or become qualified for – by reason of education, training or experience – due solely to Illness or injury, you will be considered totally disabled for the purpose of this provision.

If you become totally disabled before age 60, your Life Insurance coverage will continue from the date premium payments on behalf of such Person cease; but in no event more than 24 months from the date Total Disability began at no cost to you. Coverage will continue without payment of premium during such disability, if:

1. You send written proof of your disability to the Fund Administrator no later than 12 months after the date of your disability, the date premium payments on behalf of such Person cease; but in no event more than 24 months from the date Total Disability began; and

2. The proof shows that you were totally disabled for at least nine months, and that such disability will presumably continue to exist.

Premiums will be waived every 12 months if you submit proof of continued total disability each year. Proof must be submitted within three months of the anniversary date the initial proof of disability was received by the Fund. It is your responsibility to obtain the appropriate forms from the Fund Administrator that are required for proof of your disability.

The Amount of Coverage That Is Continued

The amount of life insurance coverage that will be continued while you are totally disabled will be the same amount that was in force at the time the premium was discontinued on your behalf as a result of your disability.

Benefits Will Continue

Benefits will continue under this extension until the earliest of:

- 31 days after the date you are no longer totally disabled;
- The date you fail to furnish proof of your continued disability (which must be within three months of the anniversary date the initial proof of disability was received); or
- The date you fail to be examined by a designated Physician, if so requested. Such an examination will not be required more than once a year after coverage has been continued under this extension for two full years.

Conversion Privilege

If you are no longer eligible for group life coverage because you cease to belong to an eligible insured class or you terminate employment, you may convert that benefit to any form of individual life coverage usually offered by the Fund, except for Term Coverage.

You will not need a medical examination to qualify for this coverage, but you must complete the application form and send it (with the first premium payment) to the Fund no later than 31 days after your group life coverage has terminated.

The face value of your new Plan cannot be more than the amount you had under the group plan. The rate you pay will depend upon your age (at the nearest birthday to the date of issue) and your class of risk at the time of conversion.

You may also convert your coverage if your life insurance benefits terminate because the Plan terminates, or because life coverage benefits for your class terminate. In this case, however, you must have been covered under the group plan for at least five years. You may convert up to the

amount of life coverage you have under this Plan, less any new amount you may have or for which you may become eligible under another group plan within 31 days of the termination – although the amount converted may not exceed $2,000.

If you should die during the 31-day period after your group life coverage has terminated, the Fund will pay the group life coverage benefits to the last beneficiary you named, whether or not you applied for an individual Plan.

CLASS 1 AND CLASS 2 EMPLOYEES AND VOLUNTARY CLASS 3 RETIRED EMPLOYEE'S AD&D COVERAGE

The benefits described in this section are fully insured with Union Labor Life Insurance Company. The Accidental Death and Dismemberment (AD&D) benefit covers loss due to an injury you sustain in an Accident that occurs while you are covered by the AD&D benefit. Dependents are not covered for Accidental Death and Dismemberment benefits.

Note: Retired Employees must elect and pay the entire cost of this coverage.

Benefit

The AD&D Benefit for a covered loss is the Full Benefit or one-half Full Benefit (as shown below in the Table of Losses and Benefits). The Plan will not pay more than the Full Benefits for all covered losses from one Accident. The AD&D Benefits for the Classes are shown in the Schedule of Benefits in the front of the booklet.

Covered Loss

"Covered loss" is defined as:

1. Shown in the Table of Losses and Benefits;

2. As the direct result of the accident, and independent of all other causes, the Person suffers a Covered Loss within 90 days after the accident; and;

3. Not excluded by the AD&D Exclusions or the General Health Limitations.

The following table shows the amounts payable for Accidental Death and Dismemberment of an insured participant.

Table of Losses and Benefits	
Loss of:	**Benefit**
Life	Full Benefit
Both Hands	Full Benefit
Both Feet	Full Benefit
Both Eyes	Full Benefit
One hand and one foot	Full Benefit
One hand and one eye	Full Benefit
One foot and one eye	Full Benefit
One hand	One-half the Full Benefit
One foot	One-half the Full Benefit
One eye	One-half the Full Benefit

Loss of hand or foot means the complete and permanent severance of the hand or foot at or above the wrist or ankle joint. Loss of an eye means the entire and permanent loss of the sight of that eye.

AD&D Exclusions

No benefits are payable under this provision for any loss caused directly or indirectly, wholly or in part, by:

1. Disease or Illness of any kind (bodily or mental), or medical or surgical treatment thereof;

2. Ptomaines or bacterial infections (except infections caused by pyogenic organisms which occur with and through an accidental cut or wound);

3. Suicide or attempted suicide, intentional self-inflicted injury, while sane or insane;

4. Participation in a riot or the commission of an assault or a felony or a civil commotion;

5. War or act of war (whether declared or undeclared), or any related to war, or insurrection;

6. Service in any military, navy or air force of any country while such country is engaged in war;

7. Police duty as a member of any military, naval or air organization;

8. Use of PCP (also known as "angel dust"), LSD or other hallucinogens, cocaine, heroine or other narcotics, amphetamines or other stimulants, barbiturates or other sedatives or tranquilizers, or any combination of one or more of these substances unless prescribed by and administered by a licensed Physician; or

9. Travel or flight in or descent from any kind of aircraft as a passenger, pilot, crew member or participant in training that is owned, operated, or leased by or on behalf of the Policyholder, a Participating Employer or the armed forces; or being operated for any training or instructional purposes;

10. Any poison or gas voluntarily taken, administered, absorbed or inhaled.

11. Parachuting, skydiving, bungee cord jumping, flying, ballooning, hang-gliding, parasailing or any other aeronautic activities except as a fare paying passenger on a commercial aircraft.

12. Competing or practicing for competition in a car, motorcycle, moped or speed boat or other vehicular race.

CLASS 1 & 2 EMPLOYEES AND CLASS 3 RETIRED EMPLOYEES VOLUNTARY DEPENDENT LIFE INSURANCE

Benefit

The benefits described in this section are fully insured with Union Labor Life Insurance Company.

Dependent Life Insurance pays a benefit if a Dependent dies while insured by this plan. The amount of the benefit is the amount determined from the Schedule of Benefits in the front of this booklet.

Note: Retired Employees must elect and pay the entire cost of this coverage.

The Dependent Life benefit will be paid in a lump sum to you, if you are living. If you are not living, it will be paid to your estate.

Dependent Life Conversion Privilege

A Dependent can convert Dependent Life Insurance to an individual Plan if coverage ends under the conditions set forth below. The Dependent must apply in writing and pay the first premium for the Plan within the conversion period.

If Your Eligibility Ends

Your Dependent can convert to an individual life insurance Plan, if their coverage ends because:

- Your employment with the Plan holder ends;
- You die; or
- You are no longer in an eligible class of Employees for a reason other than:

    a. Termination of the group Plan;
    b. Termination of the Employee Life Insurance; or
    c. Your employer ceases to be covered employer.

If Dependent life conversion is chosen in this event, the individual Plan will be for an amount equal to the terminated Plan, unless the insurer agrees to convert a lesser amount.

If Your Dependent's Eligibility Ends

Your Dependent can convert to an individual life insurance Plan, if their coverage ends because:

- You are no longer married; or
- He or she reaches the age limit for a Dependent child.

In this event, the individual Plan will be for an amount equal to or less than the amount of the terminated Plan.

If Dependent Life Insurance Terminates

A Dependent can also convert to an individual life insurance Plan if:

- The Group Life Plan or the Dependent Life Plan terminates for their eligible Dependent class; and
- He or she has been insured for Dependent Life coverage for at least five consecutive years on the date of such termination.

In this event, the amount of the individual Plan will not be more than the lesser of:

- $500; or
- The amount of Dependent Life Insurance which terminated reduced by the amount of any life insurance the Dependent is or become eligible for, under a group Plan issued or reissued by the insurer or by any other insurer during the conversion period.

Notice of Conversion Rights

If your Dependent does not receive notice of the right to convert at least 15 days before the end of the conversion period, they will have an additional period to apply. This additional period will:

- Be the 25-day period which follows the date the Dependent is given such notice, but will in no case expire more than 60 days after the end of the conversion period; and
- Not be deemed a part of the conversion period, in any case.

Notice in writing that is given to you in person or is mailed to your last known address by the **Fund** Administrative Office will constitute notice for the purposes of this conversion privilege.

Death Benefit During Conversion Period

The amount of coverage your Dependent would be entitled to convert will be paid under the Dependent Life Insurance:

- if they die during the conversion period, and before the effective date of the individual Plan; and
- whether or not they had applied and paid the first premium for the individual Plan.

CLAIMS INFORMATION

Coordination of Benefits

Members of a family are often covered by more than one group health plan. As a result, two or more plans will often cover the same expense. To avoid costly duplication of benefit payments, your health plan provides a Coordination of Benefits provision. This provision affects all your health coverage, including those described in separate booklets or inserts. In no event will the Plan pay more than it would have paid had it been your only coverage. (Exception: if you and your spouse are covered under the Blue Select or Blue Plus plans, the Plan will coordinate benefits for PPO providers up to 100% of the allowable expenses.)

How Coordination Works

If you or your Dependents are also covered under another group plan, the total amount received from all plans will never be more than 100% of allowable expenses. Benefits are reduced only to the extent necessary to prevent any person from making a profit on his or her coverage.

Allowable expenses are any necessary and reasonable expenses covered by the Plan for medical or dental services, treatment or supplies covered by one of the plans under which you or your Dependents are covered.

A plan is considered to be any group plan providing coverage for medical treatment or services on an insured or self-funded basis. This includes group blanket or franchise insurance, group Anthem Blue Cross, group Blue Shield, group practice and any other group prepayment coverage, labor-management trusteed plans, union welfare plans, employer organizations plans, any coverage under governmental programs and any coverage required or provided by law, including mandatory state no-fault auto insurance.

This Coordination of Benefits provision shall not apply to any other coverage for which you pay the entire premium.

Which Plan Pays First

If one plan does not have a Coordination of Benefits provision, that plan always pays its benefits first (and is known as the primary).

If both plans have a Coordination of Benefits provision, the plan that covers you as an Employee pays first. If you are covered as an Employee under two plans, the plan which has covered you longer is primary. However, if you are covered as an active Employee under one plan and as a laid-off Employee or Retired Employee under another plan, the plan that covers you as an active Employee will pay its benefits first – this does not apply if neither plan has provision regarding laid-off or retired Employees.

If a Dependent child is covered under two plans, the plan of the parent whose birthday occurs earliest in the calendar year pays its benefits first. If both parents have the same birthday, the plan which has covered the Dependent child for the longer period pays its benefits first. If the parents of a Dependent child are divorced or separated, the plan of the parent with custody is the primary. If the parent with custody re-marries, the "order of payment" is as follows:

- The natural parent with whom the child resides;
- The stepparent with whom the child resides; and
- The natural parent not having custody of the child.

This order of payment can change if the divorce decree directs one of the parents to be financially responsible for the health care expenses of the child.

Right to Obtain or Release Information

The Fund may obtain or release any information necessary to implement these provisions.

You must declare any coverage you or your dependents have under other plans. The Fund can pay to another paying organization amounts warranted to satisfy the intent of this provision, and to the extent of such payment is discharged from liability for that claim. The Fund can also recover from the insured, from another insurance company, or from another organization or person, amounts that are overpaid under this provision.

Information necessary for the administration of this provision will be required of you at the time a claim is submitted.

Medicare

Unless you elect otherwise, this Plan will provide primary coverage for you and your spouse if you are an Active Employee age 65 or over and eligible for Medicare. Benefits under this Plan will cease should you select Medicare as your primary coverage.

If you are an Active Employee and become eligible for Medicare because of total and permanent disability, then you will no longer be considered an Active Employee and Medicare will pay first. If you are the disabled Dependent of an Active Employee, this Plan will continue to provide primary coverage at age 65.

All Participants must apply for Medicare Part B upon reaching age 65.
If you are eligible for Medicare because you have end stage renal disease, this Plan will continue to provide primary coverage for the first 30 months of your eligibility for Medicare.

If you are a Retired Employee or the spouse of a Retired Employee, Medicare will provide your primary coverage. Benefits will be coordinated with Medicare, as if Medicare had been primary and as if Participants are covered by both Medicare Part A and Part B. Benefits that are not covered by Medicare will not be covered by the Plan.

Injuries or Illnesses Caused by a Third Party

Funds Right of Reimbursement

A Participant may receive benefits from the Fund for expenses incurred due to an injury or illness caused by a third party. The Participant may also receive payments from the third party resulting from the exercise of any right to recovery – whether by suit, Worker's Compensation recovery, settlement, claims for uninsured, under insured motorist protection or otherwise. The Fund shall have the right be reimbursed by the Participant in the event of such recovery.

Upon request for benefits relating to injuries or a condition for which a third party may be liable, the Participant shall at that time advise the Fund that a third party may be liable and provide any additional information requested by the Fund.

The Participant shall agree in writing to a subrogation agreement as required by the Fund with a lien upon all sums of money recovered by the Participant from any source and regardless of the type or label applied to the sums in connection with such injuries ("Recovery") to the extent of the benefit payments the Fund has made. The Fund's right of reimbursement will apply to the first dollar of any Recovery. The Fund's lien applies to the Recovery regardless of the extent to which the sums are traceable to particular funds or assets. The Fund holds in a constructive trust the Recovery to the extent of the benefit payments made by the Fund. No benefits will be paid by the Fund unless the participant agrees in writing to execute the Trust Fund's subrogation agreement. The Participant will do nothing to prejudice the rights given to the Fund by this provision without its consent.

The Participant will advise the Fund within 90 days of the date of occurrence if, at any time after applying for benefits, he or she:

1. Learns that a third party may be liable for causing the need for treatment; or

2. Files a claim, or institutes an action against a third party for said injuries or condition.

The 90 day notification period begins on the date of the first to occur (1 or 2).

Whether or not the preceding requirements are satisfied, the Trustees shall be automatically assigned such person's right of action against the employer or other third party (or their respective insurers) and shall have the right to intervene at any time in any action brought against an employer or other third party (or their respective insurers) to recover any benefits paid.

In no event will the Fund be entitled to recover more than the total expenses paid by the Fund on the Participant's or Dependent's behalf as a result of injuries caused by a third party. In the event a Participant or Dependent fails to reimburse the Fund under this provision for any reason, the Health Fund has the right to pursue its lien against the Participant or Dependent and to offset benefits paid on the Participant's behalf from future medical benefits to which the Participant may be entitled.

Pursuant to the terms of the subrogation agreement, the "common Fund doctrine" and the "make whole rule" shall have no application to the Fund's reimbursement rights. The Fund's right to reimbursement from the Recovery is not subject to any other common law of equitable defense, including, but not limited to, a defense that the Recovery is no longer in the possession of a constructive trustee or is otherwise dissipated or not traceable.

Workers' Compensation

This Plan does not provide coverage for work-related injuries and/or disabilities. However, if payment is provided for such services, the Fund shall be entitled to establish a lien upon such benefits up to the amount paid for the treatment of the injury or disease which was the basis of the person's claim under workers' compensation law, occupational disease law, or similar legislation. The Participant shall cooperate with the Fund to ensure the Fund's lien rights are adequately protected and the provisions set forth above under the "Fund's Right of Reimbursement" shall be applicable.

CLAIMS AND APPEALS PROCEDURES

The procedure for filing claims and appeals for the Medical and Dental Plans is described in the following pages.

- If you are enrolled in one of the HMO plans, please refer to the booklet or Evidence of Coverage (EOC) provided by your HMO for information on the HMO's claims and appeals procedures.

- If you are enrolled in the SIMNSA dental plan, Vision or Prescription Drug plan please refer to the provider brochures for the claims and appeals procedures.

- For Life and AD&D claims and appeals, please refer to the Union Labor Life Insurance Company Certificate of Group Insurance.

The Plan's claims procedures include administrative safeguards and processes designed to ensure and to verify that benefit claims determinations are made in accordance with governing Plan documents and that, where appropriate, the Plan provisions have been applied consistently with respect to similarly situated individuals.

How to File Claims

You must send written notice of a self-funded medical or dental claim to the Fund Administrator within 90 days after an expense or loss occurs. If you cannot send notice within that time, you must send it as soon as reasonably possible but no more than 12 months after the expense was incurred, except in the case of legal incapacity.

Submit your Self-Funded Medical and Dental Notice of Claim to:

San Diego UNITE HERE Health Fund
P.O. Box 1618
San Ramon, CA 94583

A claim will be considered to have been filed as soon as it is received at the Fund Administrative Office, provided it is complete, with all necessary documentation required by the notice of claim. If the claim is not complete, you or your authorized representative will be notified of the additional evidence required to establish whether or not a claim should be paid. The Fund Administrator may, for example, request supplementary documentation or the results of a physical examination or laboratory test in order to adjudicate a medical claim.

This notification will be provided to you or your authorized representative as soon as reasonably possible, but not later than 5 days for a pre-service claim or 24 hours for an urgent care claim. For an urgent care claim, however, the Trust does not require prior authorization. the notice may

be provided to you or your representative orally, unless you or your representative requests a written notice.

If you fail to cooperate with such requests, your claim may be denied.

If your claim is denied, in whole or in part, a notice of an adverse benefit determination will be sent to you or your representative.

"Adverse benefit determination," as used in this booklet, is defined as a denial, reduction, or termination of benefit, including the failure to pay a benefit due to the application of any utilization review, ineligibility, or a determination that it is experimental, not Medically Necessary, or appropriate.

Forms

When the Fund Administrator receives the notice of claim, they will send a claim form to you for filing proof of loss. If the Administrator does not send the claim form within 15 days, you will be deemed to comply with the proof of loss requirements by sending written proof of loss as set forth below. Written proof must be submitted:

- To the Fund Administrator; and
- Within 90 days after the end of each period for which the benefits are to be paid.

Claims should be filed within 90 days after you incur the medical expense. Claims will still be considered for payment when it is not possible to provide notification within 90 days; however, claims will not be paid if they are submitted more than 12 months after the expense was incurred, except in the case of legal incapacity.

You should always file your claims as soon as possible.

Proof of Loss

In case of a health claim for expense or loss for which a periodic benefit is paid while the loss continues, you must send written proof of loss:

- To the Fund Administrator; and
- Within 90 days after the end of each period for which the benefits are to be paid.

In the case of a health claim for any other expense or loss, you must send written proof of loss to the Administrator within 90 days after the date expense or loss is incurred. The Fund Administrator will not deny or reduce a claim due to the fact that you are not able to send the proof of loss within 90 days, if you send the proof of loss:

- In no case, but for the lack of legal capacity, more than one year after it is the date the expense is incurred.

Benefit Determinations

Claims for benefits under the Plan will be processed, and benefit determinations will be made, within the time frames allowed under the regulations depending on the type of claim submitted. There are four types of claims that may be filed under this Plan. A description of these claims and the benefit determination time period are as follows:

1. Urgent Care Claim – Any claim for medical care or treatment that must be determined promptly to avoid jeopardizing your life, health or ability to regain maximum function, or in the opinion of the attending physician could subject you to severe pain if care or treatment is not received. If you require urgent care, you should seek immediate medical attention. No prior authorization is required for urgent care claims.

2. Pre-Service Claim – Any claim for a benefit that requires you to obtain approval before you receive medical care or treatment. This includes any prior authorization before you see a specialist or non-PPO provider, before any Hospitalization, or to obtain a higher benefit payment for an item or service.

   You will be notified by the Plan of the benefit determination (whether adverse or not) not later than 15 days after receiving your claim by the Plan.

3. Post-Service Claim – Any claim for medical care or treatment that you have already received.

   You will be notified of an adverse benefit determination not later than 30 days after receipt of your claim by the Plan.

4. Concurrent Care Claim – Any claim that results from the termination or reduction of previously granted benefits to be provided over a period of time. The Plan will notify you in advance of the termination or reduction to allow you time to appeal the decision and obtain a determination before the benefit is reduced or terminated.

   Any request to extend a course of treatment is governed by the standards generally applicable to such claims.

5. Total Disability – Any claim for extension of benefits resulting from Total Disability (the inability of a person to engage in any business or occupation for which he or she is or becomes qualified by reason of education, training or experience). You will be notified of the decision (whether adverse or not) not later than:

- 45 days from the receipt of your claim form, doctor's certification, copy of State Disability Insurance (SDI) OR Worker's Compensation check stub certifying to the dates of disability; or
- Within an additional 30 days if sufficient information has not been received and, therefore, a decision is not possible and is beyond the control of the administrator; or
- Within additional 30 days after the first 30-day extension if a decision has not been made because it is beyond the control of the administrator.

Notice will be given to you of each extension and the reasons thereof before the end of the first 45-days and again before the end of the first 30-day extension and before the end of the last 30-day extension.

To Whom Benefits Are Payable

Any health benefits payable for loss of your life will be paid to your designated beneficiary. Except as set forth below, any other benefits that have not been paid when you die may be paid either to your beneficiary or to your estate, at the option of the Fund Administrator. All other amounts will be paid to you.

Benefits Unpaid at Death – Incompetency

Benefits may be payable to any person or institution entitled to such payment, up to $500 of available benefits, that:

- Are to be paid at the time of your death; or
- Are to be paid to a minor who is not able to execute a valid release, and for whom no guardian has been appointed.

To the extent of the payment, the Fund Administrator will have no more liability under the group Plan.

Physical Examination and Autopsy

The Administrator shall have the right and opportunity to order the examination of Participant by a Physician of its choice, to determine the extent of any sickness or injury for which a claim is made. This right may be used as often as it is reasonable to do so. If a Participant dies, an autopsy may be required (where the law does not forbid it). Such an examination or autopsy shall be made at the expense of the Administrator.

Extensions for Pre-Service And Post-Service Claims

The initial determination of benefits will be made as soon as possible after the Plan receives your claim, according to the period of time indicated above. The initial benefit determination period may be extended as follows:

1. Pre-Service Claim – The initial 15-day benefit determination period may be extended up to an additional 15 days if special circumstances beyond the control of the Plan require an extension of time to process the claim. If such an extension is required, you will be sent a written notice before the expiration of the initial 15-day period, stating the special circumstances requiring the extension and the date a decision on the claim can be expected.

2. Post-Service Claim – The initial 30-day benefit determination period may be extended up to an additional 15 days if special circumstances beyond the control of the Plan require an extension of time to process the claim. If such an extension is required, you will be sent a written notice before the expiration of the initial 30-day period, stating the special circumstances requiring the extension and the date a decision on the claim can be expected.

Incomplete Claims

If you fail to follow the filing procedures or do not provide sufficient information for a pre-service or post-service benefit determination, you will be given at least 45 days to perfect your claim or provide any requested information. The time period for making a decision will be suspended from the date of the notification to the earlier of: (1) the date on which a response is received by the Plan, or (2) the date established by the Plan for furnishing the requested information (at least 45 days).

Notice of Claim Denial

If the Plan makes an adverse benefit determination, in whole or in part, you will be notified in writing of the determination and will be given the opportunity for a full and fair review of the benefit decision. The written notice of denial will include:

1. The specific reason or reasons for the denial;

2. Reference to specific Plan provisions on which the denial is based;

3. A description of any additional material or information necessary for you to perfect your claim and an explanation of why that material is necessary;

4. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your

claim; these relevant documents include any information that was relied upon, submitted, considered or generated in the course of making the benefit decision;

5. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request;

6. If a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, and the applicable diagnosis and treatment codes with their corresponding meanings, will be provided to you at no cost upon written request will be provided to you free of charge upon request; and

7. A description of the Plan's appeal procedures including a statement of your right to bring a civil action under section 502 (a) of ERISA following an adverse determination on review.

Appeals Procedures

If you apply for benefits and your claim is denied, or if you believe you did not receive the full amount of benefits to which you are entitled, you have the right to petition the Plan for a review of the denial of your claim.

The petition must be in writing, state the reason or reasons for disputing the denial and must be accompanied by any pertinent material not already furnished to the Plan. You or your authorized representative must file the appeal with the Plan within 180 days after you receive the notice of claim denial.

The Plan will review all submitted comments, documents, records and other information related to the claim, regardless of whether the information was submitted or considered in the initial benefit determination. The Plan will not give deference to the initial adverse benefit determination. The Plan will ensure that all claims on appeals will be decided through a process that guarantees independent and impartiality of the adjudicators.

If the adverse benefit determination is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not Medically Necessary or appropriate), the Plan will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. The health care professional will be an individual who is neither the individual consulted in connection with the initial benefit determination nor the subordinate of such individual. The Plan will provide you with the identification of any medical

or vocational expert whose advice was obtained in connection with an adverse benefit determination, without regard to whether the advice was relied upon in making the benefit determination.

If the Plan relies or uses new evidence, or develops a new reason to deny a disability benefit claim, the Plan will share this information with you as soon as possible. The Plan will do so before the appeal deadline so that you will have a fair chance to respond.

Appeals Determination Time Period

The time period for a benefit determination on review will begin at the time an appeal is filed under the Plan as instructed above, without regard to whether all the information necessary to make a benefit determination on review accompanies the filing. You must, therefore, make sure that your claims appeal is complete and any documentation or evidence is included with your claims when you file your appeal. You will be notified of the decision of the Plan in writing as follows:

1. Pre-Service Claim – You will be notified of the benefit determination not later than 30 days after receipt by the Plan of your request for review of an adverse benefit determination.

2. Post-Service Claim* – A properly filed appeal will be reviewed by the Appeals Committee for the Board of Trustees at its next regularly scheduled meeting. However, if the appeal is received within 30 days prior to the meeting, the appeal may be reviewed at the second meeting following receipt of your appeal.

   If special circumstances beyond the control of the Plan) require an extension of time, the Board of Trustees will render a decision at the third scheduled Board meeting following receipt of the appeal. The Plan will provide you, prior to the start of the extension, with a written notice of the extension describing the special circumstances and the date that the Appeals Committee will make its decision. A written notice of the decision on an appeal will be provided to you within 5 calendar days following the Board of Trustees meeting.

   *In the event that you want or need additional time to present evidence in support of your petition for review, you may request such additional time in writing. The Trustees will grant your written request for additional time necessary to perfect a petition for review, provided the written request is received before the Trustees issue their decision. Requests for additional time and requests to submit additional information received after the Trustees' decision has been rendered will be denied, unless the Trustees, in their sole discretion, determine that the information is material to the petition and could not have been provided earlier.

3. Disability Claims – You will be notified if a claim is wholly or partially denied within 45 days of the date of receipt of the claims. You will have up to 180 days from the receipt of the notice of denial to appeal the decision.

    a. You will receive a response within 45 days from the date the appeal is received. This period may be extended for up to an additional 45 days if additional information is required and you will be notified for the special circumstances and the date that the Plan expects to render the benefit determination.

In the case of an adverse benefit determination on the appeal, the written denial will indicate:

1. The specific reasons for the denial;

2. A reference to the pertinent Plan provisions on which the denial is based;

3. A statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits;

4. A statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures;

5. A statement of your right to bring a civil action under section 502 (a) of ERISA;

6. If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request;

7. If a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that the explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, and the applicable diagnosis and treatment codes with their corresponding meanings, will be provided to you at no cost upon written request will be provided free of charge upon request;

8. For disability appeals, an explanation as applicable why the views of a treating doctor, vocational expert, medical or vocational expert hired by the plan, or the Social Security Administration's disability decision were not followed or disagreed and

9. A statement that you and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to

contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

The failure to file an appeal within the 180-day period from the initial denial of your claim will constitute a waiver of your right to a review of the denial of your claim.
"Relevant," as used in this section, is defined as a document, record, or other information that (i) was relied upon in making the benefit determination; (ii) was submitted, considered, generated, or relied upon in the course of making the determination, without regard to whether such document, record, or other information was relied upon in making the determination; (iii) demonstrates compliance with the administrative processes and safeguards required in making the benefit determination; or (iv) constitutes a statement of Plan or guidance with respect to the plan concerning the denied treatment option or benefit for the claimant's diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.."

If you do not understand English and have questions about a claim denial, contact the Administrator to find out if assistance is available.

SPANISH (Español): Para obtener asistencia en Español, llame al **(619) 849 -1060**

Special Notes:

Claims and Appeals Procedures for the Kaiser or SIMNSA Medical plans, SIMNSA Dental, Prescription Drugs, Vision plan and Life, and AD&D Benefits:

If the benefits involved are provided by an insurance company, insurance service, health maintenance organization, or other similar organization, that organization may be entitled to conduct the review and make the decision. Disputes concerning benefits provided by one of Kaiser or SIMNSA medical plans, SIMNSA Dental or Union Labor Life Insurance Company for the Life and AD&D Benefits, generally must be resolved using the appeal procedures established by that organization. See the applicable booklet or Evidence of Coverage (EOC) for details of the organization's claims and appeals procedures.

Authorizing a Representative

The claims and appeals procedures outlined above do not preclude your authorized representative from acting on your behalf in pursuing a benefit claim or appeal of an adverse benefit determination. In order to determine if an individual or firm has been duly designated by you, a form authorizing such entity to act as your representative must be completed and received by the Plan. However, if a claim involves urgent care, the Plan will permit a health care professional with knowledge of your medical condition (i.e., a treating Physician) to act as your authorized representative.

EXTERNAL REVIEW OF CLAIMS

This External Review process is intended to comply with the clinical (ACA) external review requirements as set forth in Interim Final Regulations implementing the ACA and in Technical Release 2010-01. For purposes of this section, references to "you" or "your" include you, your covered dependent(s), and you and your covered dependent(s)' authorized representatives; and references to "Plan" include the Plan and its designee(s).

Only claims that involve medical judgment (including, but not limited to, issues related to the medical necessity, appropriateness, level of care, a determinate that a treatment is experimental or investigational) and rescission of coverage are eligible for external review.

If your appeal of a claim, whether urgent, concurrent, pre-service or post-service claim, is denied, you may request further review by an independent review organization ("IRO") as described below. Generally, you may only request external review after you have exhausted the internal review and appeals process described above. This external review process pertains only to the self- funded fee-for service medical and dental plans.

The IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.

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

External Review of Standard (Non-Urgent) Claims

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

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

1. Preliminary Review of Standard Claims.

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

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

2. Within one (1) business day of completing its preliminary review, the Plan will notify you in writing as to whether your request for external review meets the above requirements for external review. This notification will inform you:

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

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

a) If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:
b) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).
c) Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.
d) If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse

Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

e) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

f) The assigned IRO will provide written notice of its final external review decision to you and the Plan within 45 days after the IRO receives the request for the external review.

g) The assigned IRO's decision notice will contain:

   i) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, health care provider, claim amount (if applicable), and reason for the previous denial);

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

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

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

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

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

vii) Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

h) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim even if the Plan appeals or seeks judicial review of the decision.

External Review of Expedited Urgent Care Claims

1. You may request an expedited external review if:

   a) you receive an adverse Initial Claim Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or

   b) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or,

   c) you receive an adverse Appeal Claim Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

2. Preliminary Review for an Expedited Claim.

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

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

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

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

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

d) The IRO will provide notice of their final expedited external review decision, in accordance with the requirements, set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review

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

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

Further, in the event a claim has been submitted for review in accordance with such procedures and the claim has been denied on the final level of appeal, no lawsuit or other action against the Plan or its Trustees may be filed after one year from the date you have been given written notice of the Trustees' or IRO's decision.

THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT

The Health Insurance Portability and Accountability Act (HIPAA), effective June 1, 1997, requires this Plan to furnish you with the following information.

Special Enrollment Rights

If you elected not to enroll your Dependents, you will have the option to enroll your Dependents during a plan year under circumstances in accordance with HIPAA legislation. The circumstances are:

- You marry; or
- You have a new Dependent child (either as the result of birth, adoption, or marriage to a person who has children); or
- Your spouse was covered under another group plan and lost eligibility, the expiration of COBRA had been reached, or there was a substantial change in the coverage or cost so that the spouse could no longer be covered; or
- You opted-out of Plan coverage pursuant to a CBA provision and have now lost eligibility under the other group health insurance;
- Your spouse or Dependent recently immigrated to the United States of America; and
- You request enrollment within thirty (30) days of the termination of coverage or the acquisition of the spouse or Dependent child through marriage, birth, adoption or placement for adoption or the date your spouse

You and your dependents may also enroll in this Plan if you (or your dependents) have coverage through Medicaid or a State Children's Health Insurance Program (ASCHIP) and you (or your dependents) lose eligibility for that coverage. However, you must request enrollment within 60 days after the Medicaid or SCHIP coverage ends.

You and your dependents may also enroll in this Plan if you (or your dependents) become eligible for a premium assistance program through Medicaid or a State Children's Health Insurance Program (ASCHIP). However, you must request enrollment within 60 days after you (or your dependents) are determined to be eligible for such assistance.

GENERAL PROVISIONS

These general provisions apply to all benefits under the group Plan.

Assignment

You may assign the benefits under the group Plan to be paid for a medical or dental care charge. This does not mean that your right to appeal under the Plan have been assigned to a provider. No other assignment of the group Plan or any rights or benefits under the Plan will have any force or effect unless and until the Fund Administrator consents to it in writing.

Incorrect Reporting

The facts shall be used to determine to what extent, if at all, a Participant is or was covered under the group Plan when:

- Any information that pertains to the Participant is found to have been reported incorrectly to the Administrator; and
- The error affects the existence or amount of coverage.

Exemptions

To the full extent the law permits, all rights and benefits that accrue under the group Plan shall be exempt from execution, attachment, or other legal process for the debts or liabilities of any Participant or beneficiary.

Workers' Compensation

The group Plan is not in lieu of, and does not affect, any requirement for coverage by Workers' Compensation insurance.

Statements, Not Warranties

All statements made by the Participant will, in the absence of fraud, be deemed representations and not warranties. No statement made by Participant or the Employee to obtain coverage will be used to avoid or reduce the coverage, unless made in writing and signed by the Participant or the Employee and a copy is sent to the Participant, the Employee or his beneficiary.

DEFINITIONS

Following are some of the terms used in this booklet. Other terms are described throughout the booklet as they are used. Please read these carefully – they can help you to better understand what your benefits are.

Accident or Accidental Injury means any damage to a body part resulting in trauma from an external source, not necessarily involving another person.

Active Member means any person employed under a Collective Bargaining Agreement between the employer and the Union, and on whose account the employer is making, or is obligated to make, contribution into this Health Fund. The term Active Member shall also include Employees of the Union as an employer making contributions on behalf of said Employees provided the inclusion of said Employees is not a violation of any existing law. Owner operators, self-employed persons, members of partnerships and independent contractors shall not be included under the definition of Active Member.

Substance Use Disorder means the addictive relationship a Participant has with a drug or alcohol agent.

Allied Health Professional means only a person shown on the list of Allied Health Professionals below, but only if:

1. The person is licensed and practices within the scope of the license; and
2. The requirements shown in the List of Allied Health Professionals are met.

The following persons will be considered Allied Health Professionals (a) only if the patient is referred to the person by a physician; and (b) only for services prescribed by the physician:

1. Physical Therapist
2. Speech Therapist, speech pathologist, or audiologist
3. Occupational therapist
4. Psychiatric-mental health registered nurse who has a master's degree and two years of supervised experience in psychiatric-mental health nursing and who is included on the State Board of Registered Nurses' list of such nurses.

Board of Trustees is established pursuant to the Trust Agreement. The Board of Trustees is the Plan Sponsor.

Collective Bargaining Agreement is an agreement between UNITE HERE Local 30 and an employer who provides for contributions to the Health Fund in accordance with the provisions of the Trust Agreement.

Complication of Pregnancy means:

1. A condition requiring Hospital confinement (when the pregnancy is not terminated) whose diagnosis is distinct from pregnancy, but is adversely affected or caused by pregnancy; and

2. Non-elective Cesarean section, ectopic pregnancy which is terminated and spontaneous termination of pregnancy which occurs during a period of gestation in which a viable birth is not possible.

Covered Charges and Covered Medical Expenses means the reasonable and customary charges incurred for the Medically Necessary treatment of conditions covered under this Plan but not more than Plan allowances payable under the Plan.

Covered Dental Service means a service that:

1. Is essential for the necessary care of the patient's teeth and supporting tissue; and
2. Is performed by a Dentist or Dental Hygienist; and
3. Has a reasonably favorable prognosis; and
4. Is a generally accepted professional practice, and meets professionally recognized standards

Dental Hygienist means a person who:

1. Has been trained in an accredited school;
2. Is licensed by the state in which he or she is practicing the art of dental prophylaxis; and
3. Is practicing under the direction and supervision of a Dentist

Dental Treatment Plan means the attending Dentist's report of a recommended Program of Dental Treatment. This report must be written on a form satisfactory to the Fund Administrator, and must:

1. Itemize the proposed dental procedures;
2. List the charge for each dental procedure; and
3. Be accompanied by any appropriate diagnostic materials (including preoperative X-rays) as may be required by the Fund Administrator.

The Dental Treatment Plan is required when a Dentist estimates the charges for a Program of Dental Treatment will be more than $1,000

Dentist means a person who:

1. is licensed to practice dentistry; and
2. is acting within the scope of their license

"Dentist" shall include a Physician who provides dental services within the scope of their license.

Dependent means any of the following:

Spouse – Your lawful spouse to whom you are legally married and from whom you are not legally separated. Common-law or other such marital arrangements are not recognized. A spouse's divorce, annulment or legal separation from the eligible Participant by a court having jurisdiction over the parties will result in termination of that spouse's eligible Dependent status. Submission of a marriage certificate is required to establish a spouse's relationship to the eligible Participant.

The Domestic Partner, as defined below, of an Active Employee or Retired Employee.

Children – Your natural child or children of your Domestic Partner under the age of 26. Dependent children include stepchildren, adopted children and children placed with you for adoption. In addition, if you are required to provide benefits for a child on the basis of a Qualified Medical Child Support Order (QMCSO), the child will also be covered for benefits, and your unmarried child or child of your Domestic Partner who is age 26 or older and who is dependent upon you for support and is incapable of self-sustaining employment due to mental or physical handicap, provided that the mental or physical handicap existed while the child was eligible and enrolled in the Plan before age 26 (which has been certified in writing by a Physician and approved by the Board of Trustees). In such event, the child will continue to qualify as a Dependent for all Dependent's benefits until the earlier of (1) the date he or she recovers from the handicap; or (2) the date he or she is no longer chiefly dependent on you for support and maintenance; or (3) the date you are no longer covered by the Plan.

Submission of a certified copy of a birth certificate, adoption papers, qualified medical child support order or court order is required to establish the child's relationship to the eligible Participant.

The Plan has detailed procedures for determining whether an order qualifies as a QMSCO. Participants can obtain, without charge, a copy of such procedure from the Fund Administrator.

The term "Dependent" does not include a person who is:

- An eligible Employee; unless both are enrolled in either the Blue Select or Blue Plus PPO Medical Plans.

Doctor or Physician means any medical Doctor (MD), Podiatrist (DPM), and Doctor of Osteopathy (DO), licensed to practice medicine in the state in which he or she practices. The term "Doctor: also includes an advanced Nurse practitioner (a certified Nurse practitioner, Nurse-midwife, or Physician assistant) if the following requirements are met:

- The service is otherwise covered under the Plan;
- The advanced Nurse practitioner's service is in lieu of the service of a Physician;
- The service is within the lawful scope of the provider's license; and
- The provider is performing services under the supervision of a duly licensed Physician if such supervision is required.

Domestic Partner means a person of the same sex or the opposite sex who is the partner of an eligible active or retired employee. The employee or Retired Employee and partner must have completed the Affidavit of Domestic Partnership available from the Fund Administrative Office and submitted it for approval or submitted their registration of their Domestic Partnership with the State before Coverage begins.

Drugs or Prescription Drugs mean any article which may be lawfully dispensed (as provided under the Federal Food, Drug and Cosmetic Act, including any amendments thereto) only upon written or oral Prescription of a Physician or Dentist licensed by law to administer it. Such items must have FDA approval for treatment of the condition for which they are prescribed.

Emergency means with respect to an Emergency Medical Condition (defined below), a medical screening examination within the emergency department of a hospital including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to the extent they are within the capabilities of the staff and facilities available at the hospital to stabilize the patient.

- The term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility, or, with respect to an Emergency Medical Condition, to deliver a newborn child (including the placenta)

-The term "Emergency Medical Condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

- The Plan Administrator or its designee has the discretion and authority to determine if a service or supply is or should be classified as an Emergency Medical Condition.

Employee means any Active Member, Self Pay or Non-Bargaining person as defined beginning on page 16.

Extended Care Facility refers to an institution that provides skilled nursing care and other related health services, or rehabilitation services for injured, disabled or sick persons, and meets all of the following requirements:

1. Is primarily engaged in providing skilled nursing care for sick or injured persons with 24-hour-a-day supervision by a Physician/surgeon (MD) or a graduate Registered Nurse (RN);

2. Has available at all times the services of a Physician/surgeon (MD) who is a staff member of a general Hospital;

3. Has on duty 24 hours a day a graduate RN, Licensed Vocational Nurse (LVN) or skilled practical Nurse, and has a graduate RN on duty at least eight hours per day;

4. Maintains a clinical record for each patient;

5. Complies with all licensing and other legal requirements; and

6. Other than incidentally, is not:

    a. A place for custodial care;
    b. A place for the aged;
    c. A place for the care of persons addicted to or dependent on a Drug or chemical, including alcohol;
    d. A place of rest; or
    e. A nursing home, hotel, or similar institution.

Family Unit means each member of the terminally ill patient's family who is a Participant.

Fund Administrator refers to BeneSys Administrators.

Home Health Care means medical care that is furnished by or through a Home Health Agency to a Participant in their home.

Home Health Agency means an agency that:

- Meets any legal licensing required by the state or other locality in which it is locate; or
- Qualifies as a participating Home Health Agency under Medicare

Hospice means an organization providing care for the Terminally Ill, and is certified by the National Hospice Organization, Federal Medicare and local licensing organizations.

Hospice Care means care that is:

- Furnished or arranged by a Hospice that is approved by the Fund Administrator;
- Provided as part of a coordinated plan of home and inpatient care designed to meet the special needs of the Terminally Ill patient and the Family Unit, due to the terminal Illness;
- Provided for the Terminally Ill patient, and may include medical care, Palliative Care, respite care and Medical Social Services; and
- Provided to the Family Unit, and may include Medical Social Services.

Interdisciplinary Team means the primary care unit that develops the overall plan of care and provides services for the terminally ill patient and his immediate family. The team must include a licensed registered Nurse and a Physician. The team may also include one or more of the following members:

- A registered Nurse or licensed practical Nurse utilized as a visiting Nurse in the patient's home; and
- A licensed social worker who has at least one year of experience working with Terminally ill patients and their families.

Hospital means a state or federally licensed institution which meets the following requirements:

1. Is primarily engaged in providing diagnostic, surgical and therapeutic facilities for medial surgical care of sick and injured persons on an inpatient basis at the patient's expense;

2. Continuously provides 24-hour-a-day supervision by a staff of Physicians licensed to practice medicine (other than Physicians whose license limits their practice to one or more specified fields), and 24-hour-a-day nursing care by or under the supervision registered Nurse;

3. Is approved by Medicare as a Hospital; and

4. Other than incidentally, is not:

    a. A place for custodial care;
    b. A place for the aged;
    c. A place for the care of persons addicted to or dependent on a Drug or chemical, including alcohol;
    d. A place of rest; or
    e. A nursing home, hotel, or similar institution.

Illness means a bodily sickness, disorder or disease.

Medically Necessary with respect to services and supplies received for treatment of an illness or injury means those services and/or supplies determined to be:

1. Appropriate and necessary for the symptoms, diagnosis or treatment of illness or injury;

2. Provided for the diagnosis or direct care and treatment of the Illness or injury;

3. Within standards of good medical practice within the organized medical community;

4. Not primarily for the convenience of the patient, the patient's Physician or another provider; and

5. It is the most appropriate supply or level of service which can safely be provided and that satisfies the following requirements:

    a. There must be valid scientific evidence demonstrating that the expected health benefits from the procedure, service, supply, drug, medicine or equipment are clinically significant. The evidence also must demonstrate that there is a greater likelihood of benefit, without a disproportionately greater risk of harm or complications, for the patient with the particular medical condition being treated than possible alternatives;
    b. Generally accepted forms of treatment that are less invasive have been tried and found to be ineffective or are otherwise unsuitable;
    c. For Hospital stays, acute care as an inpatient is necessary due to the kind of service the patient is receiving, the severity of the medical condition, and
    d. That safe and adequate care cannot be received as an outpatient or in a less intensified medical setting.

Medical Social Services means counseling furnished to the Terminally Ill patient or the Family Unit to assist each in coping with the dying process of the Terminally Ill patient.

The counseling may be furnished by a social worker or a pastoral counselor, but only if such person is licensed and practicing within the scope of their license.

Medicare means any health benefits or health care program established under Title XVII of the Social Security Act of 1965 (as amended or renumbered from time to time).

Nurse refers to a graduate Registered Nurse who does not ordinarily reside in the same household as you or your covered Dependent, and who is not a member of your immediate

family. Nurse also means a Licensed Practical or Vocational Nurse who does not ordinarily reside in the same household as your or your covered Dependent, and who is not a member of your immediate family, but only if:

- Services of a Registered Nurse is not available; and
- The services provided are the same as those of a Registered Nurse.

Palliative Care means care that is rendered to relieve the symptoms or effects of a disease, without curing the disease.

Participant means any person eligible for benefits under the Plan, whether as an Employee, Retired Employee or Dependent.

Pharmacist means a person who is licensed to practice pharmacy by the governmental authority having jurisdiction over the licensing and practice of pharmacy.

Plan means the San Diego UNITE-HERE Health Fund and the program of benefits it provides, as amended from time to time, by the Board of Trustees

Program of Dental Treatment means all treatment that is done or is to be done in the oral cavity at one or more sessions, as the result of the initial diagnosis.

The program shall include the treatment for any complications that arise during the program.

Relative means the patient's:

- Father, mother, brother, sister, son or daughter; or
- Any other person related by blood or marriage residing at the same address as the patient.

Relative Value Schedule means list of relative value units for certain procedures multiplied by the dollar value for the procedure to determine the allowance for certain services.

Skilled Nursing Facility means an institution that:

1. Is duly licensed as a convalescent Hospital, Extended Care Facility, Skilled Nursing Facility, transitional care unit or intermediate care facility and is operated in accordance with the governing laws and regulations;

2. Is primarily engaged in providing accommodations and skilled nursing care 24- hours a day for convalescing persons;

3. Is under the full-time supervision of a Physician or a registered graduate Nurse;

4. Admits patients only upon the recommendation of a Physician (other than the patient's own Physician), maintains complete medical records, and has available at all times the services of a Physician;

5. Has established methods and procedures for the dispensing and administering of drugs;

6. Has an effective utilization review plan;

7. Is approved and licensed by Medicare;

8. Has a written transfer agreement in effect with one or more Hospitals; and

9. Is not, other than incidentally, a nursing home, a hotel, a school or similar institution, a place of rest, for custodial care, for the aged, for drug addicts, for alcoholics, for the care of mentally ill or persons with nervous disorders, or for the care of senile persons.

Specialized Care Centers refers to institutions which are properly licensed by appropriate state agencies to provide care, such as coma centers and special rehabilitation centers. Such care is available only through pre-admission review or case management.

Ambulatory Surgical Center means any public or private establishment which meets all the following requirements:

- complies with all legal requirements and is Medicare approved;
- is set up, equipped and operates primarily for the purpose of performing surgical procedures;
- provides continuous Physician services and registered nursing services while patients are in the facility;
- does not provide services or other accommodations for patients to stay overnight; and
- extend surgical staff privileges to Doctors who practice surgery in a local Hospital.

Terminally Ill means a medial prognosis of 12 months or less to live, as diagnosed by a licensed Doctor of medicine (MD) or osteopathic Physician (DO).

Totally Disabled when used in reference to the Health Plan coverage means that you are prevented from engaging in your regular or customary occupation or employment, due solely to injury or Illness. With respect to your insured Dependent: it means that he or she, due solely to injury or Illness, is prevented from engaging in substantially all of the normal activities of a person of like age and gender who is in good health.

YOUR ERISA RIGHTS

As a Participant in certain of the various Employee benefit plans described in this guide, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants will be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Fund Administrative Office or at other specified locations, all documents governing the Plan including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Fund Administrator with the US Department of Labor, and available at the Public Disclosure Room of the Employee Benefits Security Administration.

- Obtain, upon written request to the Fund Administrator, copies of all documents governing the operation of the Plan, including insurance contracts and Collective Bargaining Agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Administrator may make a reasonable charge for these copies.

- Receive a summary of the Plans' annual financial report. The Plan's administrator is required by law to furnish each Participant with a copy of such summary annual reports.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse or Dependents if there is a loss of coverage under the Plan as a result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing your COBRA continuation coverage rights.

Prudent Actions by Plan Fiduciaries

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

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of Plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Fund Administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in state or Federal court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and legal fees. If you lose, the court may require you to pay these costs and legal fees, if, for example the court finds your claims is frivolous.

Assistance With Your Questions

If you have any questions about your Plan, you should contact the Fund Administrator. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Fund Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory, or the Los Angeles Regional Office, 1055 East Colorado Blvd, Suite 200, Pasadena, CA 91106-2341 (phone number (626) 229-1000) or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration,

U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at (866) 275-7922.

ERISA Information

1. Plan Name and Plan Sponsor

The Plan is known as the San Diego UNITE-HERE Health Fund.

The Plan Sponsor is:

Board of Trustees of the San Diego UNITE-HERE Health Fund
3737 Camino Del Rio South, Suite 300
San Diego, California 92108

2. Plan Identification Numbers

The employer identification number is EIN 95-1708883

The Plan number is PN 501

3. Type of Welfare Plan and Funding Organization

The Plan is a collectively bargained, jointly-trusteed labor-management trust. A complete list of the employers and employee organizations sponsoring the Plan may be obtained upon written request to the Fund Administrator and is available for examination at the Fund Administrator's office.

This welfare Plan provides Hospital, medical, prescription drug, mental health and chemical dependency, dental, vision, life insurance and accidental death and dismemberment benefits for active and retired Employees and their dependents.

4. Organizations Through Which Benefits are Provided:

The carriers listed below provide fully insured benefits under the Plan:

Kaiser Permanente Southern California Region Walnut Center Pasadena, CA 91188	Provides insured prepaid medical benefits.
SIMNSA 303 H Street, Suite 309 Chula Vista, CA 91910 (619) 407-4082	Provides insured prepaid medical and dental benefits.

Union Labor Life Insurance Company 8403 Colesville Road Silver Springs, MD 20910 (800) 431-5425	Provides insured Life and Accidental Death & Dismemberment.

The Plan is self-funded (claims are paid directly from the assets of the Fund) for the benefits listed below. These carriers administer at least a portion of the benefits for the Plan, but do not ensure or otherwise guarantee any of the benefits of the Plan:

Vision Service Plan (VSP) 3333 Quality Drive Rancho Cordova, CA 95670 (800) 877-7195	Administers the vision benefit and provides access to its network of vision providers. For Active Employees and dependents only.
Sav-Rx 224 North Park Avenue Fremont, NE 68025 (800) 228-3108	Administers the prescription drug benefit and provides access to its network of pharmacies for Participants enrolled in the fee-for- service medical plan.
Anthem Blue Cross 21555 Oxnard Street Woodland Hills, CA 91367 (800) 999-3643	Provides case management and access to its network of Hospitals and medical providers
Bonita Dental 5050 Bonita Rd. Bonita Rd., CA 91902 (858) 292-8180	Provides a contracted dental office for participants enrolled in the dental plan.
First Dental Health P.O. Box 919029 San Diego, CA 92191 (800) 334-7244	Provides a network of contracting dentists for participants enrolled in the dental plan.

5. Type of Administration

This Plan is administered by a Third-Party Contract Administrator.

6. Fund Administrator

The Fund's Administrator, the Board of Trustees, has contracted with the following third party administrator for administrative services:

BeneSys Administrators
3737 Camino Del Rio South, Suite 300
San Diego, CA 92108

The Administrator's telephone number is (619) 849-1060.

7. Agent for Service of Legal Process

The person designed as Agent for Service of legal process is:

Fund Administrator
BeneSys Administrators
3737 Camino Del Rio South, Suite 300
San Diego, CA 92108

Service of legal process may be made upon the Fund Administrator or any Trustee.

8. Source of Plan Contributions

Benefits are provided primarily from employer contributions determined as a result of Collective Bargaining. A self-payment is required for Retired Employee coverage and for enrollment in some higher cost plans.

9. Date Fiscal Year Ends

The fiscal year for this Plan ends, each year, on December 31.

10. Claims Procedures

The Claims and Appeals Procedures are detailed beginning on page 87.

11. Collective Bargaining Agreements

Contributions to the Plan are made by Contributing employers on behalf of each Employee in accordance with Collective Bargaining Agreements between the Employees and Employers in the industry. In certain circumstances, employees self-pay for coverage. The Fund Administrator will provide you, upon request, with a copy of the applicable Collective Bargaining Agreement. You will be charged a reasonable amount for copying.

12. Trustees of the Plan

The names, titles, and business address of the Trustees of the Plan as of January 1, 2025 are as follows:

Administered by:
BENESYS ADMINISTRATORS
3737 Camino Del Rio South, Suite 300
San Diego, CA 92108
(619) 849-1060

MANAGEMENT TRUSTEES

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