# SIGN, PICTORIAL & DISPLAY INDUSTRY

# BENEFIT PLAN

# SUMMARY PLAN DESCRIPTION

**January 1, 2025**

## INTRODUCTION

This booklet is the Summary Plan Description ("SPD") of your Benefit Plan effective January 1, 2025. The "Highlights" section briefly describes the eligibility rules and benefits available under the Plan. The next section is the detailed summary of the eligibility rules and benefits. This is followed by the Claims and Appeals Procedures and a description of your rights under ERISA.

The summaries that follow are provided for your convenience and are not intended to differ from the Formal Plan Rules. If there is any difference between this summary and the Formal Plan Rules, the Formal Plan Rules govern. All of the rules of the Plan are subject to modification by the Board of Trustees. Any amendments to the Formal Plan Rules, or changes to the contracts with Plan carriers, which are adopted by the Trustees after the publication of this booklet, supersede the summaries in this booklet.

The Formal Plan Rules, including a complete description of all self-funded benefits provided by the Plan, may be provided upon request. For a complete description of all benefits provided through Kaiser, see the separate booklet provided by Kaiser.

## Important Information about the Plan

1. Plan members may select one of two options for medical coverage: the Self-Funded PPO Plan or Kaiser Foundation Health Plan. If you are a new member, you must choose an option by completing an enrollment form and returning it to the Plan Administration Office.

2. If you acquire a new dependent, you must enroll that dependent within 30 days to be assured of the right to enroll the dependent. If you do not meet that deadline, you may be required to wait until the next open enrollment period. Contact the Plan Administration Office whenever you acquire a new dependent, or when any of the following events occur:

- Change of name
- Change of address
- Change in marital or domestic partnership status
- Change in beneficiary
- Change or addition of eligible dependents
- Member or dependent becoming eligible for Medicare

3. Only the Plan Administration Office may confirm your eligibility status or accept appeals to the Board of Trustees concerning the Self-Funded PPO Plan or your eligibility for benefits under Kaiser. Appeals on issues related to specific benefits and coverages provided by Kaiser, such as medical necessity, must be submitted to Kaiser.

**Please be aware of the following time limitations regarding claims and appeals and third party reimbursement rights**:

- With limited exceptions any claim for benefits under this Plan, together with proof of the claim, must be submitted no later than 12 months after the date of service.

- If you are dissatisfied with an action or decision of the Plan Administration Office or other agent of the Board of Trustees, you may appeal that action to the Board of Trustees within 180 days of receiving notification of the unfavorable action or decision. You must submit a written request for appeal of the unfavorable action or decision to the Plan Administration Office, or you will be deemed to have waived your objections to it. See the section entitled Claims and Appeals Procedures for details regarding how to file an appeal. The Board of Trustees' decision with regard to an appeal is final and binding on all parties.

- A lawsuit based on the Board of Trustees' denial of benefits or any other action or dispute must be filed within one year from the date the Board gives you notice of its decision.

- Class Actions: By participating in the Plan, you and your family members agree to waive, to the fullest extent permitted by law, whether or not in court, any right to commence, be a party in any way, or be an actual or putative class member of any class, collective, or representative action arising out of or relating to any dispute, claim or controversy relating to the Plan, and you and your family members agree that any dispute, claim or controversy may only be initiated or maintained and decided on an individual basis.

- Third Party Reimbursement Rights: If you or your dependent has an injury or sickness caused or allegedly caused by a third party's act or omission, the Plan will pay benefits for that injury or sickness, subject to its right to reimbursement from any amount recovered by reason of the third party's act or omission, on the following conditions: (1) that you or your dependent (or legal representative) will not take any action which would harm the Plan's reimbursement rights, and (2) that you or your dependent (or legal representative) will cooperate in doing what is reasonably necessary to assist the Plan in enforcing its reimbursement rights. The Plan's reimbursement right will be for 100% of benefits paid, regardless of whether or not you or your dependent has received full or any compensation.

4. This group health plan believes it is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the "Affordable Care Act"). Under the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on non-essential benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Plan Administration Office, 7180 Koll Center Parkway, Suite 200, Pleasanton CA 94566.

You may also contact the Employee Benefits Security Administration, U. S. Department of Labor at 1-866-444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

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## ALPHABETICAL SUBJECT INDEX

## PLAN SERVICES PROVIDERS

Plan Administration Office

Eligibility, medical and dental claim inquiries, life insurance claims, and appeals on matters under the discretion of the Board of Trustees:

BeneSys Administrators .....(925) 398-7048
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566
Website: www.ourbenefitoffice.com/Sign510/Benefits/

Local Union

The Local Union also provides assistance on Plan benefits:

Sign, Display & Allied Crafts Local Union No. 510 .....(650) 763-5405
400 Talbert
Daly City, CA 94014

Other Providers

Kaiser Member Services .....(800) 464-4000
or www.kaiserpermanente.org

Blue Shield of California
For Utilization Review and Customer Service.....(800) 541-6652
To Find a PPO Provider..... www.blueshieldca.com/networkPPO
or call 1-888-877-8363

Vision Service Plan ..... (800) VSP-7195 (800-877-7195)
or www.vsp.com

Sav-Rx.....(800) 228-3108
or www.SavRx.com

Aetna Dental Access
To find a PPO dentist ..... www.aetna.com
Follow instructions to find a dentist in the Aetna Dental Access plan

Claremont Employee Assistance Program dba Uprise Health (800) 834-3773
or www.claremonteap.com

United of Omaha Life Insurance Company ..... (800)-775-8805

## HIGHLIGHTS OF THE PLAN

### Who is eligible to participate?

This Plan covers employees working under collective bargaining agreements in positions for which contributions are required to be made to this Plan (also known as bargaining unit employees or Class A participants).

The following other people may also participate:

- Qualified contributing employers, partners, self-employed contractors and proprietors (also known as Class B participants) who are signatory to a collective bargaining agreement with the Local Union and pay the required monthly charge, and their enrolled non-bargaining unit employees (also known as Class D participants).

- Full-time officials and full-time employees of participating local unions, qualified active trustees of the Welfare Fund and their surviving spouses, and qualified retired trustees (also known as Class C participants).

- Retired employees and retired employers who satisfy the appropriate eligibility rules for retiree coverage and who pay the required monthly charge which applies to their coverage.

- Eligible dependents of all of the above, including your lawful spouse or registered domestic partner; and your natural children, adopted children, foster children and stepchildren, until age 26 for medical benefits.

### If I am a bargaining unit employee, how do I become eligible for coverage under the Plan?

Eligibility is based on your reserve account of hours which are reported and credited on your behalf for each hour of covered employment. A month of coverage under the Plan for Shop/Regular Status Employees "costs" 125 Hours, and for Installers "costs" 85 hours.

To qualify for coverage, Shop/Regular Status Employees must be credited with a total of 250 hours within two consecutive months. Installers must be credited with a total of 170 hours within two consecutive months. In order for you to receive credit, the participating employer must submit payment for your benefit contributions.

This Plan uses a "double skip month" eligibility system. Hours worked in Month One are reported by the employer in Month Two, and provide health coverage for Month Four.

For example, let's say you are a Regular Employee and work at least 250 hours in January and February. Your work hours in January and February will be reported and paid to the Plan in February and March. When the total of the hours reported and paid to the Plan on your behalf reaches 250 in March, you will be covered under the Plan starting on May 1.

You can check your eligibility at www.sign510benefits.org

**How do I maintain monthly eligibility?**

Shop/Regular Status employees maintain eligibility by having a reserve account of at least 125 covered hours at the beginning of each month. Installers maintain eligibility by having a reserve account of at least 85 covered hours at the beginning of each month. See page 8 and Plan Document, Part 1, Section 1, for more details.

The Plan's "double skip month" eligibility system also applies to maintaining monthly eligibility: hours worked in Month One are reported by the employer in Month Two, and provide health coverage for Month Four.

**What benefits are provided?**

There are currently two options for medical, surgical, and hospital benefits:

○ The Self-Funded PPO Plan (a "preferred provider organization," or PPO); and

○ Kaiser Foundation Health Plan (a "health maintenance organization," or HMO).

The Self-Funded PPO Plan pays benefits to you, or directly to your provider, for health care which is medically necessary and prescribed by a licensed provider. The PPO Plan pays benefits for most types of care, regardless of whom you use as providers, but **you will pay significantly less if you use PPO providers**. The Plan's current PPO for medical benefits is Blue Shield of California. Medical benefits under the Self-Funded PPO Plan are not subject to a calendar year deductible. You can request a copy of the criteria for medical necessity or medically necessary determinations from the Plan Administration Office.

Under Kaiser, you pay a fixed fee for each covered visit, which may vary with the type of service. However, Kaiser requires that you use only their doctors and facilities, and have all your health care handled through a primary care physician.

The Plan provides a variety of other benefits:

- Dental benefits are provided by the Self-Funded PPO Plan for active bargaining unit participants.
- Prescription benefits are provided by the medical option in which you enroll: either the Self-Funded PPO Plan or Kaiser.
- Vision care benefits are provided through Vision Service Plan for active bargaining unit participants.
- Life insurance is provided through United of Omaha for active bargaining unit participants. Fill out a beneficiary card and keep it current.
- Help with personal and work-related problems and issues, including drug and/or alcohol dependence, is coordinated by the Claremont Employee Assistance Program for bargaining unit participants and their dependents.
- The Plan also provides an orthotics benefit and a smoking cessation benefit.

All of these benefits are summarized in this booklet beginning on page 22.

**Are my dependents covered?**

Your eligible dependents are covered when you are covered and have enrolled them. Be sure to inform the Plan Administration Office immediately if you get married, register a domestic partnership, have a child, or if a child is placed with you for adoption. Enroll new dependents within 30 days of the birth, marriage, or other event which makes them eligible, or you may have to wait until the next open enrollment period. Please note, if you enroll your domestic partner in the Plan, then you will be subject to tax on the imputed income, or value of the premium, for coverage of your domestic partner under the Plan.

Your eligible dependents lose coverage when you lose coverage, or, in the case of your children, when they reach the Plan's age limitations. Dependents who lose coverage are eligible for the Plan's COBRA continuation coverage. See page 16 and Plan Document, Part 1, Section 3, for Dependent Eligibility for Health Coverage. See page 18 and Plan Document, Part 1, Section 8, for COBRA continuation coverage.

**What happens if I am disabled?**

Bargaining unit participants who become disabled due to an occupational or non-occupational disability may receive coverage at no charge for up to six months. See page 10 and Plan Document, Part 1, Section 1.06, for more details.

**What happens if I am out of work?**

Reserve Account: Hours credited and paid on your behalf which exceed those needed for current eligibility are reserved in your account to allow coverage in periods of unemployment. The maximum reserve you may accumulate is 4 full months of coverage: 500 hours for Shop/Regular Status Employees and 340 hours for Installers.

Self-Pay: Shop/Regular Status employees who are credited with a minimum of 90 hours in a month may make a short payment to bring the total up to 125. Installers who are credited with a minimum of 60 hours in a month may make a short payment to bring the total up to 85.

**How does the Federal No Surprises Act Apply to the Self-Funded PPO Plan?**

Self-Funded PPO Plan: Under the No Surprises Act, non-contracted providers and facilities are generally prohibited from sending you a balance bill for any eligible expenses in excess of the Plan's charges for services in the below circumstances. This means you will pay at the PPO-contracted rate for:

(a) Emergency services at an non-contracted health care facility
(b) Non-Emergency services provided by a non-contracted provider at a PPO-contracted facility
(c) Out-of-network air ambulance services

A balance bill is the amount billed by the out-of-network provider when you receive non-contracted services which are in excess of the Plan's charges for the services. A "surprise billing" is an unexpected balance bill. This happens when you cannot control who is involved in your care, such as when you experience an emergency or when you schedule a visit with a PPO-contracted facility but are unknowingly treated by an non-contracted provider, as noted in (a), (b) and (c) above.

In addition to the protections against receiving balance bills from these non-contracted providers, your cost-sharing percentage will be the same as if you had received services from a PPO-contracted provider. This means that once you have met your deductible, those cost-sharing amounts will be applied to your out-of-pocket maximum.

These special rules only apply to the types of services listed above. Other non-contracted services remain subject to the normal rules of the Plan.

The rules under (a) and (b) above will not apply in circumstances if you consent to receive treatment from a non-contracted provider for either post-stabilization treatment or non-emergency treatment at a PPO-contracted facility. If that happens, as with other non-contracted services, you will be responsible for payment of the applicable non-contracted coinsurance, as well as any balance bills for amounts in excess of the Plan's charges for those services.

**What happens if I am hospitalized?**

Self-Funded PPO Plan: If you are going to be hospitalized, utilization review is required for most services, except for emergency admissions, and inpatient mental and emotional illness treatments. See Plan Document, Part 2, Section 13, for details. Approved hospital charges are paid at 90% at PPO-contracted facilities, without a deductible. At non-contracted facilities, approved hospital charges are paid at 70% after a $200 deductible, unless the No Surprises Act applies, in which case hospital charges are paid at 90% without a deductible. See above, or Plan Document, Part 1, Section 11.14 for more details regarding the No Surprises Act.

Kaiser: There are no charges at a Kaiser hospital.

**What happens if I have surgery?**

Self-Funded PPO Plan: Surgeon's fees and facility charges are paid at 90% for PPO providers, without a deductible.. For non-PPO providers, surgeon's fees and facility charges are paid at 70%, after a $200 deductible applied to the facility charge, unless the No Surprises Act applies, in which case surgeon fees and facility charges are paid at 90% without a deductible See above, or Plan Document, Part 1, Section 11.14 for more details regarding the No Surprises Act.

Kaiser: There are no surgeon charges at a Kaiser hospital.

**What happens if I go to a hospital emergency room?**

Self-Funded PPO Plan: If you have an accident and go to a hospital emergency room, you will be responsible for the first $50 of covered charges.

Kaiser: If you go to a Kaiser emergency room, you are responsible for a $35 copay.

**How do life insurance benefits get paid?**

The life insurance benefit will be paid to the person you have named on your beneficiary designation form. Be sure to fill one out and keep it updated.

## ELIGIBILITY FOR BENEFITS

### 1. Employee Eligibility - Bargaining Unit Employees (Class A Participants)

Eligibility for benefits as a bargaining unit employee is determined by your credited and paid hours of covered employment. When you work in covered employment and have hours reported, paid and credited on your behalf to the Plan Administration Office, a reserve account of hours is established for you. Each month, your reserve account is credited with the hours that were reported for work performed in the month three months prior. For example, hours reported for work performed in February will be credited to your reserve account in May.

Your work hours will be credited when contributions on your behalf have been reported and paid by your employer for each hour that you worked. If your employer has not paid contributions on your behalf, your work hours will not be credited. The Board of Trustees may discontinue crediting of unpaid work after three months of unpaid eligibility.

Bargaining unit employees are classified as Shop/Regular Status Employees or Installers.

Initial Eligibility - Shop/Regular Status Employees. A new Shop/Regular Status Employee, or a Shop/Regular Status Employee returning to covered employment after a period of extended unemployment, will become eligible for benefits under this Plan on the first day of the third month following any two consecutive months in which the Shop/Regular Status Employee has been credited with a total of 250 or more hours of work and the participating employer has submitted payment for your contribution benefits. .

Initial Eligibility - Installers. A new Installer, or an Installer returning to covered employment after a period of extended unemployment, will become eligible for benefits under this Plan on the first day of the third month following any two consecutive months in which the Installer has been credited with a total of 170 or more hours of work and the participating employer has submitted payment for your contribution benefits.

Continuing Eligibility - Shop/Regular Status Employees. After establishing initial eligibility, continuing eligibility for a Shop/Regular Status Employee requires having a reserve account of at least 125 hours at the beginning of each month. If a Shop/Regular Status Employee is credited with more than 125 hours of covered employment in any month, the excess hours are added to a reserve account which will be used when necessary to continue coverage in months when less than 125 hours are worked. A Shop/Regular Status Employee may accumulate a reserve account of up to 500 hours.

Shop/Regular Status employees who have been credited with at least 90 hours in a particular work month may make a self-payment, in an amount to be determined by the Board of Trustees, to continue coverage, so long as the credited hours have also been paid by the participating employer.

Continuing Eligibility - Installers. After establishing initial eligibility, continuing eligibility for an Installer requires having a reserve account of at least 85 hours at the beginning of each month. If an Installer is credited with more than 85 hours of covered employment in any month, the excess hours are added to a reserve account which will be used when necessary to continue coverage in months when less than 85 hours are worked. An Installer may accumulate a reserve account of up to 340 hours.

Installers who have worked been credited with at least 60 hours in a particular work month may make a self-payment, in an amount to be determined by the Board of Trustees, to continue coverage, so long as the credited hours have also been paid by the participating employer.

Special Eligibility Rules: If you or your spouse are a sole or part owner of a participating employer entity, the Plan will not continue your eligibility unless the participating employer has paid all outstanding amounts due to the Plan, including but not limited to employer audit shortages and assessed liquidated damages and interest on previous untimely paid contributions.

Termination of Eligibility. Your coverage will terminate at the end of any month in which the combination of your newly credited and paid hours and reserve account hours falls below the applicable requirement: 125 hours for Shop/Regular Status Employees and 85 hours for Installers. Shop/Regular Status Employees who are credited with at least 90 hours in a month, and Installers who are credited with at least 60 hours in a month, may make self-payments to continue coverage, as explained above. If your reserve account and credited hours are too low to continue coverage by self-payments, your coverage may be continued under the Plan's COBRA continuation coverage rules. See page 18 and Plan Document, Part 1, Section 8, for COBRA rules.

Your coverage will also terminate at the end of any month in which you continue to work for a participating employer after you have been notified by the Plan that the participating employer is delinquent on contribution payments and you have been instructed to leave that employment.

Reinstatement. If your coverage has been terminated, any remaining hours in your reserve account may be used to qualify for reinstatement within six months from your termination. Shop/Regular Status Employees would not have to be

credited with 250 hours of covered employment to be covered again, and Installers would not have to be credited with 170 hours to be covered again. Instead, Shop/Regular Status Employees will be reinstated on the first day of the third month following the month in which newly credited hours and reserve account hours total 125 hours (or total at least 90 in a single work month and a short payment is made to bring the total up to 125), and Installers will be reinstated on the first day of the third month following the month in which newly credited hours and reserve account hours total 85 hours (or total at least 60 in a single work month and a short payment is made to bring the total up to 85), provided the participating employer has submitted payment for the credited hours. However, if you do not qualify for reinstatement within six months, your reserve account hours are forfeited and you must requalify for initial eligibility as explained above.

Disability Coverage. If you become disabled due to an occupational or non-occupational disability, you may receive coverage at no charge for up to six months.

Initial Coverage: To receive the initial 3 months of extended disability coverage, you must meet all of the following tests: 1) be disabled in a single month for more than one-half of the hours required for eligibility; 2) be eligible for Plan coverage, either due to active hours of employment, including coverage using your reserve account hours, or self- payments, when you became disabled; 3) be receiving State Disability Insurance ("SDI") benefits or have filed a Workers' Compensation claim related to the disability; and 4) submit satisfactory proof of a qualifying disability to the Plan Administration Office.

Extended Coverage: You may qualify for an additional 3 months of extended disability coverage if, when you became disabled, you: a) were disabled in a single month for more than half the number of monthly hours required for eligibility; and b) were eligible for Plan coverage, either due to active hours of employment, including coverage using your reserve account hours, or self-payments, for the prior twelve consecutive months; and c) had either filed a workers' compensation claim related to your disability or were receiving State Disability Insurance payments.

Extended disability coverage starts the first day of the month following the month in which the qualifying disability arose, and continues until the earlier of: 1) you are no longer disabled, or 2) you have received the maximum number of months of disability coverage allowed. When extended disability coverage ends, coverage may be continued by use of any remaining reserve account hours, or under COBRA continuation coverage rules. If you applied for a Social Security Disability Award, no final determination has been made by the Social Security Administration, and the initial 18 months of COBRA continuation coverage have

been exhausted, you may appeal to the Board of Trustees for extended coverage under COBRA on a month by month basis.

## 2. Employee Eligibility - Class B, C and D Participants (Employers and Non-Bargaining Unit Employees)

Class B Participants are employers (partners, self-employed contractors and proprietors, and their officers, managers and shareholders) who are signatory to a Collective Bargaining Agreement with a participating local union, who are actively engaged in their business and devote not less than 25 hours a week to the business and who elect to be covered under the Plan, but only if all such partners, officers, managers and shareholders are enrolled in coverage under the Plan.

Class C Participants are full-time officials and full-time employees of a participating local union, which elects to insure all their officials and employees under the Plan, all trustees of the Welfare Fund who have served as Trustees for at least five years, surviving spouses of covered Trustees, and all retired Trustees who were appointed as trustees before January 1, 2014 and who served at least ten years (not necessarily continuously) as trustees. Temporary employees, and employees who work less than 30 hours per week, shall not be considered full time employees.

Class D Participants are active full-time non-bargaining unit employees employed by those employers who contribute to the Fund as Class B participants, provided that all full-time employees are included for coverage under the Plan. Temporary or seasonal employees, or employees who work less than 30 hours per week shall not be considered full-time employees.

Initial Eligibility. Class B, C and D participants become covered on the first day of the second month following two consecutive months from the date application for coverage is approved by the Trustees, provided the sum equal to two months' premium cost for each eligible employee is received in advance by the Plan Administration Office.

An employer must apply for coverage of all of its Class B and D employees within 31 days from the date the employer becomes signatory to a Collective Bargaining Agreement with a participating local union, and, for employees hired thereafter, within 31 days from the date of hire.

Continuation of Eligibility. From time to time, the Board of Trustees may require documentation that covered Class B, Class C, and/or Class D participants continue to meet the eligibility requirements for coverage under the Plan.

Termination of Coverage. Coverage for Class B, C and D participants will terminate:

1. on the last day of the month following the month in which the last timely payment was made for this coverage;

2. on the last day of the month following the month in which the employer did not pay the contribution owing on behalf of its Class A participants;

3. on the last day of the month following the month during which employment is terminated;

4. on the last day of the month following the month in which the Plan is modified to terminate coverage on the unit or class of employees to which the covered person belongs;

5. on the last day of the month following that month in which the employer or self-employed contractor or proprietor has withdrawn as an active employer signatory to a Collective Bargaining Agreement; or

6. for Class B Participants, on the last day of the second month following any two consecutive months in which the weekly average of working hours is less than the 25 hours required above for initial eligibility; or

7. on the last day of the month in which any documentation required to show that you meet the eligibility rules for coverage is not provided.

Termination of coverage under these rules is final, and coverage can only be re-acquired if the Plan's rules for initial eligibility are met. If your coverage terminates because of a termination of employment or reduction of hours, you may be eligible for COBRA Continuation Coverage; see page 18 and Plan Document, Part 1, Section 8.

### 3. Coverage During Military Service

If your health coverage ends because of your service in the Uniformed Services, you may elect to continue your coverage, if required by the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), until the earlier of:

(a) the end of the period during which you are eligible to apply for reemployment in accordance with USERRA; or

(b) 24 consecutive months after your coverage ended.

If you are called to active military duty for a period of 31 days or longer:

(a) You may continue coverage for you and your eligible dependents under one of the following options:

(1) You may freeze your reserve account as of the first day of the month following the commencement of active service and pay the full premium under the Plan, which includes the employer's share and any retroactive premium, plus 2% for administrative costs; or

(2) You may elect to have your reserve account hours applied for coverage, at the normal monthly charge, until your reserve account is exhausted, at which time you may continue coverage for you and your eligible dependents by paying the monthly charge described in (1) above for the remaining months of the maximum coverage period.

(b) In lieu of electing coverage for yourself and your dependents, you may elect to have your reserve account hours applied for coverage of only your eligible dependents until it is exhausted, and thereafter continue coverage for your eligible dependents under COBRA.

(c) You have 60 days from the day you leave employment for uniformed service to elect continuation coverage for yourself and/or your eligible dependents under this rule. If no election to continue coverage is made, your reserve account will be frozen as of the first day of the month following your departure for service, and coverage for you and your eligible dependents will terminate. If you are excused under USERRA from providing notice of your departure for service, your coverage may be reinstated retroactively upon your election to continue coverage and payment of all unpaid amounts due.

If you are called to active military duty for fewer than 31 days, you may continue coverage for you and your eligible dependents without payment by you of any premium.

## 4. Family and Medical Leave Act

If you work for an employer that is required to provide health and welfare plan coverage under the Family and Medical Leave Act ("FMLA") during a qualifying leave under FMLA, and you are eligible for, and take, such leave, then your benefits will be continued during the period of FMLA leave. Your employer must notify the Plan Administration Office in writing if you are eligible for, and take FMLA leave. During FMLA qualifying leave, your employer is legally obligated to make the required contribution for coverage for you and your eligible dependents, which will be established under rules determined by the Board of Trustees. Your reserve account will not be used to provide coverage until the qualified FMLA leave ends.

Crediting of hours for your coverage, and your employer's obligation to contribute for coverage during your FMLA leave, will terminate when your FMLA leave ends. Your employer must notify the Plan Administration Office in writing when your FMLA leave ends. If you do not return to work for the employer at the end of your FMLA leave, you may be eligible for COBRA Continuation Coverage, with termination of FMLA leave as the qualifying event under COBRA. See page 18 and Plan Document, Part 1, Section 8.

If requested by the Plan Administration Office, you or employer must submit documentation that your leave is in accordance with FMLA.

## 5. Loss of Coverage for Cause

Even if you would otherwise satisfy the rules of eligibility, your eligibility for benefits will be cancelled if you are caught moonlighting, working for or as a non-signatory employer in the Sign, Pictorial & Display Industry, or commit gross misconduct.

Under these circumstances, all of your accumulated hours will be cancelled, and you must requalify for coverage under the Plan as a new employee. You may not make self-payments during the three or more months that it takes to qualify again for coverage. The only coverage which may be available is COBRA coverage, and it is available only if you have had a qualifying event as defined in the law.

## 6. Retired Employee Eligibility

If you are a qualified employee who retires from covered employment, you may be eligible for retiree medical coverage, if you meet all the following requirements:

a) you are actually receiving benefits from the Sign, Pictorial & Display Industry Pension Plan; and

b) you have been eligible as an active employee for at least one month out of the twelve months prior to retirement (or if you worked under a Collective Bargaining Agreement which provides only for medical benefits but not for pension benefits, you were continuously covered as a bargaining unit employee for the ten years prior to your retirement); and

c) you have been covered as an active employee for at least 90 months in the 10 years prior to retirement; and

d) you applied for coverage no later than the effective date of your retirement; and

e) you have made all required payments; and

f) if you, your spouse or your dependents are eligible for Medicare, you, your spouse and your Medicare-eligible dependents must be enrolled in <u>both Part A and Part B of Medicare</u>; and

g) if you, your spouse or your dependents are eligible for Medicare, you may enroll in Kaiser only if you elect the Kaiser Senior Advantage plan, which requires that you reside in the Senior Advantage service area and assign your Medicare to Kaiser.

In determining whether you have satisfied the above requirements under subsections (b) and (c), the Plan Years 2020 and 2021 will not be considered.

<u>Retiree Benefits</u>: The Plan provides medical coverage and prescription drug benefits only; life insurance, dental and vision coverage, and benefits coordinated by Claremont Behavioral Services dba Uprise Health, are not provided to retirees or their dependents.

To receive retiree coverage, you must apply to the Plan Administration Office and pay a monthly charge, determined from time to time by the Board of Trustees. Your payment must be received by the 10th day of the month preceding the month for which you are purchasing coverage.

Your spouse or registered domestic partner is also eligible for coverage if you are eligible, but only if you have been married, or registered as a domestic partner, for at least one year when your retirement benefits commence. Your children are eligible for medical coverage only, for an additional monthly premium for each

child, if you are eligible, and if the child meets the requirements for eligibility stated in section 7 below. If your spouse or registered domestic partner drops retiree medical coverage under the Plan, they can only opt back in upon providing to the Plan Administration Office verification of continuous coverage of group employer medical coverage during each month of absence from this Plan, and verification that the loss of employer provided group coverage is due to loss of employment or other reason for why the employer coverage is no longer available.

The prescription drug benefits for retirees provided under the Self-Funded PPO Plan and Kaiser are considered "creditable" with Medicare Part D, as of the date of this booklet. If you receive prescription drug benefits under either available option, you should **not** enroll in an individual Medicare Part D plan.

Suspension of Health Coverage If You Return to Work: If you return to work in Industry Service for forty (40) hours or more in any month, your retiree medical coverage will be suspended for one year. To reinstate retiree medical coverage after the one-year suspension, you must re-enroll in the retiree medical plan starting with the first calendar month after the end of the one-year suspension period or your eligibility for retiree coverage will terminate permanently. If you return to work in Industry Service for a second time for forty (40) hours or more in any month, your retiree medical coverage will be suspended permanently.

If you return to work as an active bargaining unit member, with a suspension of benefits from the Sign, Pictorial and Display Industry Pension Plan, in order to requalify for active coverage, you must meet the requirements for initial eligibility for bargaining unit employees.

Retiree coverage is also available for qualified Class B and Class C participants.

## 7. Dependent Eligibility for Health Coverage

The Plan provides benefits for your eligible dependents, subject to completion of the proper enrollment forms. For health coverage, your eligible dependents are:

a) your lawful spouse or registered domestic partner; and

b) your child(ren) up to the Plan's age limitation (generally age 26, but see below for details).

The term "Child" means any of the following:

a) your natural child;

b) your stepchild, child of your registered domestic partner, foster child, or any child under your legal guardianship;

c) any minor child placed with you for the purpose of legal adoption, from the moment the child is placed in your physical custody, or from the moment you have assumed and retained a legal obligation to provide total or partial support for the child in anticipation of adoption of the child, whichever is earlier.

The Plan also covers your natural or adopted children, when you have been ordered to maintain their coverage in a court order called a "Qualified Medical Child Support Order" ("QMCSO") or equivalent. If the Plan receives a Medical Child Support Order, it will review it promptly to determine if it is qualified. The determination that an order is not a QMCSO is appealable to the Board of Trustees. The Plan procedures for review of QMCSOs are available free of charge from the Plan Administration Office.

Your dependent is not eligible for coverage if any of the following conditions apply:

a) he or she lives outside the United States;

b) he or she is on active duty in the Armed Forces of any country;

c) he or she has coverage under the Plan as a dependent of another person, and 1) the dual coverage is at the expense of the Plan; or 2) the chosen medical plan's coverage rules do not allow dual coverage; or

d) he or she ceases to be your spouse or domestic partner, due to divorce or dissolution of your domestic partnership; or ceases to be your child, due to adoption by another person or by reaching the Plan's age limitation.

Age Limitation for Health Coverage: Children are covered until their 26th birthday for medical benefits. Coverage may be continued after a child's 26th birthday if he or she has a physical or developmental disability which began before coverage would otherwise have ended, and which makes him or her incapable of self-sustaining employment and chiefly dependent upon you for support. Proof of the disability must be provided within 31 days of the termination of regular coverage of the dependent, and from time to time as requested by the Plan Administration Office thereafter.

Dependent Eligibility Rules for Life Insurance: For life insurance benefits, different dependent eligibility rules and age limitations apply; see page 41 and Plan Document , Part 5, Section 20.

Coordination of Benefits: If you or your dependent is also covered by another health plan, the benefits under this Plan and the other plan will be coordinated. This means one plan pays its full benefits first, then the other plan pays. See Plan Document, Part 1, Section 11.02, for the complete Plan rules regarding Coordination of Benefits.

Coordination with Medicare: This Plan will be secondary with respect to Medicare for a covered person whenever allowed by law. When this Plan is secondary with respect to Medicare, Medicare benefits are determined first. Then, Plan benefits will be paid, but the combined Plan and Medicare benefits shall not exceed the amount that would have been paid by the Plan in the absence of Medicare.

Dual Coverage: When both spouses or domestic partners are eligible under the Plan as employees, they may be covered as an employee; a dependent spouse or domestic partner; or both an employee and a dependent spouse or domestic partner. When both parents of a child are covered as employees, the child may be covered as a dependent of either or both parents. When an individual is eligible both as an employee and as a child, he or she may be covered as an employee, a child, or both an employee and a child. In such cases, benefits will be paid in accordance with the Coordination of Benefits provisions, and the combined benefits will not exceed 100% of the actual eligible charges incurred.

## 8. COBRA Continuation Coverage

Every covered person who loses coverage due to a qualifying event may be eligible for COBRA Continuation Coverage. Qualifying events include the death of the participant, divorce from the participant, ceasing to qualify as a dependent child, loss of coverage due to termination of employment or low hours, and loss of coverage due to a failure of the participant to return to work after the expiration of FMLA leave. Under certain circumstances, a dependent has a separate right to elect COBRA coverage.

If you become eligible for COBRA coverage on the grounds of termination of employment or low hours as a bargaining unit employee, the Plan Administration Office will notify you. If you are a covered Individual Employer or non-bargaining unit employee, and you will lose coverage because of termination of your employment or your low hours, your employer must notify the Plan Administration Office, and then you will be given your COBRA election; however, you may also give notice.

To be eligible for COBRA coverage on any grounds other than termination of employment or low hours, you or your dependents must provide notice of the qualifying event within 60 days. You or your dependents must notify the Plan Administration Office if you or any of your dependents will be losing coverage because of any of the following reasons:

a) your death;

b) your divorce or dissolution of your domestic partnership;

c) your child no longer qualifies as an eligible dependent, because he or she has reached age 26; or

d) you have become eligible for Medicare.

You or your dependents must also return your COBRA election form within 45 days of receiving it, and pay the premium retroactively to your qualifying event.

**It is your responsibility to meet the deadlines of COBRA coverage.**
You and/or your dependents will lose the right to COBRA coverage if you or they fail to give a required notice of a qualifying event, or fail to make a COBRA election in the time allowed, or fail to make a payment on time.

COBRA coverage is available for up to 18 months, in the case of termination of employment or low hours, 29 months in the case of a qualifying disability, or 36 months in other cases. If a second qualifying event occurs while under COBRA coverage, a dependent may elect to receive the remaining months of the 36-month period.

COBRA coverage is not available under the following circumstances:

a) if an employee is terminated for working for a non-contributing employer, or for gross misconduct on the job; or

b) if a non-bargaining unit employee loses coverage because the person's employer is no longer qualified to participate, voluntarily stopped participating, or failed to make a required payment.

See Plan Document, Part 1, Section 8, for COBRA continuation coverage rules.

The Plan's COBRA coverage is offered to you based on the Plan's full cost. You may be able to purchase lower cost health coverage in the Covered California

marketplace, and you may qualify for a premium tax credit, depending on your individual circumstances. To compare COBRA coverage under this Plan with a Covered California plan, you should consider the total premium that you will have to pay for you and your dependents, the doctors and hospitals available under each plan, and the copays and deductibles charged under each plan. You must apply for and select a Covered California Plan no more than 60 days after your coverage under this Plan ends. To learn more, contact Covered California. The website is www.coveredca.com.

**9. Extended Coverage for Surviving Spouses or Domestic Partners**

**Active Employees**: The surviving spouse or registered domestic partner of a long-term active employee (that is, an employee who was covered under the Plan for 90 months in the 10 years preceding his or her death) may continue coverage for up to six years after the employee's death. To qualify, the surviving spouse or domestic partner must enroll within the time allowed for COBRA continuation coverage, maintain coverage continuously by paying the required premium, and may not marry or register a new domestic partnership, other than as provided below.

If a surviving spouse or domestic partner remarries or reregisters a new domestic partnership, as the case may be, within 3 years of the employee's death, that spouse or domestic partner may continue COBRA coverage for any months remaining in the original 36-month COBRA period.

If the surviving spouse or domestic partner marries or registers a new domestic partnership after the original 36-month period, coverage will terminate on the first day of the month following the remarriage or domestic partnership registration.

**Retirees**: The surviving spouse or registered domestic partner of an eligible retiree may also extend coverage for up to six years.

**10. Continuity of Care**

If you or your dependent is currently receiving treatment at a provider or facility for any of the conditions listed below, and the provider or facility has a change in their contractual relationship (including changing from an in-network facility/provider to an out-of-network facility/provider) then the covered person may request to continue to have services provided under that current provider or facility under the same terms and conditions as if no contractual change had occurred. The eligible conditions are:

a) a Serious and Complex Condition;

b) the course of treatment for Pregnancy;

c) the duration of a Terminal Illness;

d) the performance of a scheduled nonelective surgery (including post-operative care); and

e) course of institutional or inpatient care.

See Plan Document, Part 1, Section 11.03, for the complete Plan rules regarding Continuity of Care.

## 11. Third Party Reimbursement

If you or your dependent has an injury or sickness caused or allegedly caused by a third party's act or omission, the Plan will pay benefits for that injury or sickness, subject to its right to reimbursement from any amount recovered by reason of the third party's act or omission, on the following conditions: (1) that you or your dependent (or legal representative) will not take any action which would harm the Plan's reimbursement rights, and (2) that you or your dependent (or legal representative) will cooperate in doing what is reasonably necessary to assist the Plan in enforcing its reimbursement rights. The Plan's reimbursement right will be for 100% of benefits paid, regardless of whether or not you or your dependent has received full or any compensation, and will not be reduced because the recovery does not fully or partly compensate you or your dependent for all losses sustained or alleged, or the recovery is not described as being related to medical costs or loss of income. The Plan will not enforce its reimbursement rights if you or your dependent's injury or sickness was the result of domestic violence.

See Plan Document, Part 1, Section 11.04, for the complete Plan rules regarding Third Party Reimbursement.

## 12. Reservation of Powers

The Board of Trustees reserves the power to revise all rules and procedures related to this Plan, including the power to terminate or change the coverage for any person or class of persons, to change the payment required for coverage, and to change the benefits payable by, or provided by, the Plan or by an insurance company, HMO, or other provider. Nothing in this summary should be construed to make any benefits under the Plan vested, or as a waiver of any discretion or power conferred upon the Board of Trustees under the Trust Agreement.

## BENEFITS

## MEDICAL PLAN OPTIONS

The Plan offers two medical plan options to all participants (provided that they live in the service areas of the plan carriers):

○ The Self-Funded PPO Plan (a "preferred provider organization" or PPO); and

○ Kaiser Foundation Health Plan (a "health maintenance organization", or HMO).

You, and your dependents, will receive all of your medical, hospital and surgical benefits through the medical plan carrier you choose. The Board of Trustees has reserved the power to change the medical plan options; you will be notified if this occurs.

### How to Enroll Yourself and Your Dependents

New participants may choose from the available medical plans and enroll dependents when they first become eligible for benefits. After initial enrollment, the Plan maintains a 'rolling' open enrollment. Covered Plan participants and dependents may change medical plans anytime during the year, but no more than once in the last consecutive 12 months (unless a change is approved by the Board of Trustees or the individual moves out of the Kaiser service area, in which case the individual must enroll in the Self-Funded PPO Plan).

If a covered Plan participant or dependent becomes eligible for Medicare and is covered under Kaiser HMO, then he/she must enroll in the Kaiser Permanente Senior Advantage Plan. Any change in plan(s) will be effective on the first day of the second calendar month following the date the enrollment form is received by the Trust Fund Office.

Special Enrollments:

1. You may enroll new dependents within 30 days of the birth, marriage, adoption, placement for adoption, or other event which makes a dependent eligible.

2. If you previously declined enrollment for yourself or your eligible dependents (including your Spouse) because of other health insurance or group health plan coverage, you may enroll them in the future within 30 days after your other coverage ends.

3. If your eligible dependents lose coverage, and/or become eligible for a special premium assistance subsidy, under Medicaid or a State Sponsored Children's

Health Insurance Plan, you must enroll them within 60 days of their loss of coverage or their becoming eligible for premium assistance.

**You must complete an Enrollment Form.**

If you are a new participant, medical benefits will be paid only after you have completed an enrollment package for a medical plan option. If you do not return a timely enrollment form for Kaiser, you will automatically be enrolled in the Self-Funded PPO Plan. Also, if you fail to enroll your dependents within thirty days, or sixty days as applicable, your dependent(s) may not be able to receive medical benefits, unless your chosen medical plan option allows it.

## Current Medical Plan Options

The following options were available when this booklet was published on January 1, 2025:

SELF-FUNDED PPO PLAN

Under the Self-Funded PPO Plan, you may see any doctor based on your medical need. However, if the doctor you choose is part of Blue Shield of California's network of preferred providers, you receive a higher level of coverage. A list of participating medical providers in the Blue Shield of California network is available, free of charge, as a separate document from the Plan Administration Office. You can also look for a doctor or other providers online at www.blueshieldca.com/ Network PPO or call 1-888-877-8363.

See the chart on page 25 for a summary of the Self-Funded PPO Plan benefits. A complete description of all self-funded benefits provided by the Plan may be found in Plan Document. A notice called Summary of Benefits and Coverages ("SBC") is also available. It is updated annually and can help you compare the current medical plan options.

An updated list of Preferred Providers will be published periodically by Blue Shield of California. For the current list, you may contact BeneSys Administrators Inc., or visit Blue Shield of California's website at www.blueshieldca.com/NetworkPPO.

The Preferred Provider Option is administered in accord with an agreement between the Plan and Blue Shield of California. The Plan does not contract directly with any Preferred Provider. Blue Shield of California contracts with these providers, and the criteria for participation in the network are determined by Blue

Shield of California. The Plan does not endorse any provider, including any Preferred Provider, nor does the Plan supervise, control or guarantee the health care services of any provider, including any Preferred Provider.

The Preferred Provider Organization for alcohol and drug dependency treatment benefits is the Claremont Behavioral Services Employee Assistance Program.

KAISER FOUNDATION HEALTH PLAN HMO

Except in cases of life-threatening emergency, Kaiser requires that all medical care and benefits be provided at Kaiser facilities and with Kaiser providers. Services and supplies must be provided, prescribed, authorized or directed by a Kaiser physician. Members choose a personal Kaiser physician who will coordinate all medical care, and must also meet Kaiser's service area residence requirement. After making a co-payment, most services are covered at 100% and there are no deductibles. There is a $25 charge for office visits, no charge for hospital stays, and a $5 charge per prescription.

See the chart on page 29 for a summary of Kaiser benefits. For more detailed information about Kaiser benefits, the conditions of treatment and/or payment, and the claims review and appeal procedures, please refer to Kaiser's Evidence of Coverage ("EOC") documents or contact Kaiser directly. To obtain a copy of these documents, call the Plan Administration Office. The summaries and tables below are not intended to supersede Kaiser's EOC, which is a binding contract. If there is any discrepancy between the summaries in this booklet and Kaiser's EOC, the EOC prevails. A notice called Summary of Benefits and Coverages ("SBC") is also available. It is updated annually and can help you compare the current medical plan options.

Appeal Procedures: Appeals of matters under the discretion of Kaiser are handled directly by Kaiser, and not through the Plan Administration Office or the Board of Trustees.

Provider Directory: Blue Shield and Kaiser each maintain a provider directory, which is updated every 90 days, and will respond to inquiries about the network status of a provider or facility within one business day. If you receive inaccurate information from Blue Shield, Kaiser, or the Plan Administration Office about a provider or facility's network status, you will be liable only for in-network coinsurance for the services underlying the inquiry. It is your responsibility to confirm that the provider or facility selected is in-network at the time you receive services.

## Self-Funded PPO Plan

| Benefit Feature | PPO* Provider | Non-PPO Provider |
|---|---|---|
| Lifetime Maximum Medical | Unlimited | |
| Annual Deductible for services | None | None |
| Deductible per Hospital Admission<br>Deductible per Emergency Room Visit | None<br>$50 | $200<br>$50 |
| Annual Maximum Out-of-Pocket Per Person (Stop-Loss)<br>(Per Confinement and ER deductibles are not included) | $1,000 | $5,000 |

| **Benefit Feature** | **PPO* Provider** | **Non-PPO Provider** |
|---|---|---|
| Covered Percentages: | | |
| Hospital Charges<br>Subject to Utilization Review and other requirements - see Plan Document for details.<br>**90% for services from a non-PPO provider which are covered under the No Suprises Act. | 90% | 70%** |
| Emergency Room (after additional ER deductible)<br>**90% for services from a non-PPO provider which are covered under the No Suprises Act. | 90% | 70%** |
| Ambulance | 90% | 70%** |
| Air Ambulance | | |
| Physician Charges – General Office Visits<br>Telehealth services will be treated as an office visit under the Plan. | 90% | 70% |
| Physician Charges – Specialist Office Visit | 90% | 90% |
| Physician Charges – Hospital Visit<br>**90% for services from a non-PPO provider which are covered under the No Suprises Act. | 90% | 70% |
| Routine Physical Exam<br>(for bargaining unit participants and dependents only) | 90% | 70% |
| Well Child Care<br>19 periodic examinations are covered at birth, at 2, 4, 6, 9, 12, 15, 18 and 24 months, and at 3, 4, 5, 6, 8, 10, 12, 14, 16 and 18 years. | 90% | 70%** |
| | 100% | 100% |
| | 90% | 70% |

*PPO providers are members of Blue Shield of California. See Plan Document, Part 1, Section 12.01, for more information. If you live outside the geographic service area of the Blue Shield network, then your co-insurance will be 80% of Reasonable and Customary Charges.

## Self-Funded PPO Plan (continued)

| Benefit Feature | PPO Provider | Non-PPO Provider |
|---|---|---|
| Covered Percentages: | | |
| Well Woman Care | 90% | 70% |
| Lab/Blood Work/X-rays/CT/PET Scans/MRIs | 90% | 70% |
| Chiropractic<br>$1000 max per calendar year | 90% | 70% |
| Home Health Care<br>100 visits per 12 months | 90% | 70% |
| Rehabilitation/Habilitation Services | 90% | 70% |
| Skilled Nursing Care | 90% | 70% |
| Durable Medical Equipment | 90% | 70% |
| Hospice | 90% | 70% |
| COVID-19 Screening and Testing | 90% | 70% |
| Mental Health – Inpatient<br>**90% for services from a non-PPO provider which are covered under the No Suprises Act. | 90% | 70%** |
| Mental Health – Outpatient<br>**90% for services from a non-PPO provider which are covered under the No Suprises Act. | 90% | 70%** |
| Substance Abuse Treatment and Rehabilitation - Inpatient Medical detoxification benefits are available to all participants. Substance abuse rehabilitation benefits are available only to bargaining unit participants and their dependents. Must be reviewed and coordinated by Claremont Behavioral Services dba Uprise Health. | 100% for 1st confinement; 90% for subsequent | 70% |
| Substance Abuse Treatment - Outpatient | 100% | 70% |

| | |
|---|---|
| Prescription Drugs<br>Available through Sav-Rx | Pharmacy: 20% copay<br>Mail Order:<br>$5 for generic;<br>$20 for brand name<br>and specialty |

The Self-Funded PPO Plan is compliant with the No Surprises Act. To the extent any provision of the Self-Funded PPO Plan is inconsistent with the No Surprises Act, the No Surprises Act shall govern.

When the No Surprises Act applies, the Plan will apply the PPO in-network coinsurance percentage to:
(a) Non-PPO Air Ambulance Services;
(b) Emergency Services for treatment of an Emergency Medical Condition by Non-PPO Providers and Non-PPO emergency facilities (unless the covered person received proper notice and consented to the out-of-network billing rates for certain post-stabilization services as allowed under the No Surprises Act); and
(c) Non-emergency services from Non-PPO Providers at PPO facilities (unless the covered person received proper notice and consented to the out-of-network billing rates as allowed under the No Surprises Act).

## Kaiser Foundation Health Plan

| Benefit Feature | Amount |
|---|---|
| Lifetime Maximum | Unlimited |
| Annual Deductible<br>Per Person:<br>Per Family: | <br>None<br>None |
| Annual Maximum Out-of-Pocket<br>Per Person:<br>Per Family: | <br>$1,500 in co-pays<br>$3,000 in co-pays |
| Hospital Charges | No Charge |
| Emergency Room | $35 co-pay per visit |
| Urgent Care | $25 co-pay per visit |
| Outpatient Surgery | $25 per procedure |
| Primary Care and Specialist Charges -<br>Office Visits to Treat an Injury or Illness | $25 co-pay per visit |
| Acupuncture (Physician-referred) | $25 co-pay per visit |
| Chiropractic Care | Not covered |
| Preventive Care/Screening/Immunization | No charge |
| Lab/X-ray/Imaging (CT/PET scans, MRIs) | No charge |
| Prescription Drugs<br>Generic<br>Brand Name/Specialty | <br>$10 co-pay<br>$25 co-pay |
| Mental Health - Inpatient<br><br>Mental Health - Outpatient | No charge<br><br>$25 co-pay for individual visit$12 for group visit |
| Substance Abuse Treatment - Inpatient Medical Detoxification Benefits<br><br>Substance Abuse Treatment - Outpatient | No charge<br><br>$25 co-pay for individual,<br>$5 co-pay for group therapy |

## Kaiser Foundation Health Plan (continued)

| Benefit Feature | Amount |
|---|---|
| Prenatal Care, Delivery and Postnatal Care | No charge |
| Habilitation Services (for skills not yet developed) | $25 per day |
| Rehabilitation Services (to regain lost skills) | Inpatient: No charge<br>Outpatient: $25 per day |
| Home Health Care (100 visit maximum per calendar year) | No charge |
| Skilled Nursing (100 day maximum per benefit period) | No charge |
| Durable Medical Equipment | No charge |
| Hospice Care | No charge |

Bargaining unit participants enrolled in Kaiser also have access to substance abuse rehabilitation benefits provided by Claremont Behavioral Services dba Uprise Health. Contact Claremont at (800) 834-3773 or www.claremonteap.com.

## INFORMATION ABOUT PARTICULAR MEDICAL BENEFITS

### Maternity Benefits Under the Newborn and Mothers Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal 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 as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

### Mastectomy Benefits Under the Women's Health and Cancer Rights Act

In accordance with federal law, women who have had a medically necessary mastectomy are entitled to coverage for:

1. all stages of reconstruction of the breast on which the mastectomy was performed; and
2. surgery and reconstruction of the other breast to produce a symmetrical appearance; and
3. prostheses; and
4. treatment of any physical complication of mastectomy, including lymphedemas.

The care covered under these rules is subject to the standard co-payment or co-insurance requirements which apply to other medical and hospital coverage provided by the plan in which the patient is enrolled.

### Preventive Services

Benefits will be provided for the following preventive services: (a) evidence-based items or services that have in effect a rating of A or B in the current commendations of the United States Preventive Services Task Force with respect to the individual involved; (b) immunizations for routine use in children, adolescents and adults that have in effect a recommendation from the Centers for Disease Control and Prevention with respect to the individual involved; (c) with respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and (d) with respect to women, evidence-informed preventive care and screenings provided for in

comprehensive guidelines supported by the Health Resources and Services Administration.

## DENTAL PLAN

Dental benefits are available to bargaining unit employees (Installers and Shop/Regular Status Employees) and Class C (full-time officials and employees of the Local Union and Trustees) participants, their eligible dependents, and to former bargaining unit employees and Class C participants who elect full COBRA coverage.

The PPO for the dental plan is Aetna Dental Access. You may use any dentist when you need care. The deductible and percentage of allowed charges will be the same whether or not you use a PPO dentist. However, if you use a PPO dentist, the amount charged by the dentist will be lower, and so your out-of-pocket costs will be less and your dental benefits will go further. To find a PPO dentist, go to www.aetna.com and follow instructions to find a dentist in the Aetna Dental Access plan.

To file a Claim, get a claim form from the Union Office or the Plan Administration Office.

Below is a brief summary of the Plan's dental benefits in effect when this booklet was published. There is no deductible for approved preventive services, such as oral exams, periodic cleaning, routine x-rays, and fluoride treatments for children under the age of 15.

| | |
|---|---|
| Annual Deductible for Preventive Services: | $0 |
| Annual Deductible for All Other Services: | $50 individual<br>$150 family |
| Percentage of Allowed Charges Paid (after deductible): | 70% |
| Annual Maximum Benefits Paid: | $3,000 |
| Orthodontia Only: | |
| Percentage of Allowed Charges Paid (after deductible): | 75% |
| Lifetime Maximum Benefits Paid: | $2,500 |

If you or a dependent lose coverage due to loss of eligibility, you may receive extended coverage for up to 30 days for a Covered Dental Charge which is already in progress. See Plan Document, Part 3, Section 17.08.

## VISION CARE BENEFITS

Vision care benefits are provided on an insured basis through Vision Service Plan ("VSP") only to bargaining unit employees (Installers and Shop/Regular Status Employees) and Class C participants (full-time officials and employees of the Local Union and Trustees), their eligible dependents, and to former bargaining unit employees and Class C participants who elect full COBRA coverage.

VSP benefits are paid for all covered vision care, but they work differently for VSP panel providers and non-panel providers. Briefly, when you see a VSP panel provider, there is a $10 co-pay for each covered benefit. VSP covers the cost of the examination, frame, and lenses, or it pays an allowance toward contact lenses. When you see a non-panel provider, you must pay the provider's bill at the time of service and, then, submit a claim for benefits to VSP. After deducting the co-payment, VSP reimburses you the allowed amounts toward your covered charges.

Whether you visit a VSP or non-VSP provider, you will be responsible for any charges in excess of what the Plan allows. In general, your out-of-pocket expense will be significantly lower if you use a VSP panel provider, because VSP panel providers have generally agreed to charge discounted rates to VSP members for services not covered by the Plan.

The following is a summary of the Plan's Vision Care Benefits. Please note that this summary is presented for your convenience only, and does not supersede the VSP booklet or contract, as in effect at the time you receive vision care benefits.

| **VSP Group: Sign Pictorial & Display Industry Benefit Plan**<br>Benefits when you use a VSP Panel Provider: | |
|---|---|
| Co-payment per exam | $10 |
| Eye examination | 100% after exam co-pay,<br>once each 12 months* |
| Prescription glasses lenses | 100% after exam co-pay,<br>once each 12 months* |
| Contact lenses | 100% after exam co-pay up to $150;<br>once each 12 months* |
| Frames | 100% after exam co-pay up to $150;<br>once each 24 months |
| Additional discounts:<br>Non-covered glasses | <br>20% |

* Frequency shown above is based on your last date of service.

An Evidence of Coverage information sheet is available from VSP, either directly or through the Plan Administration Office. VSP's Evidence of Coverage states in detail the exact amounts of benefits paid, and any exclusions, limitation, and conditions for benefits. VSP's Customer Service number, for booklets or assistance with claims, is (800) VSP-7195 (877-7195). You may also go to the VSP website, www.vsp.com, to check your own eligibility, get a list of participating doctors, and other information about your benefits and the VSP program.

## PRESCRIPTION DRUG BENEFITS

KAISER HMO

If you are enrolled in the Kaiser HMO, you and your dependents will receive all of your prescription drug benefits from Kaiser's contracted facilities. All prescriptions must be filled at Kaiser pharmacies. There is a $10 co-payment per generic prescription and a $25 co-payment per brand name prescription at Kaiser.

SELF-FUNDED PPO PLAN

If you are enrolled in the Self-Funded PPO Plan, prescription drug benefit payments for you and your dependents are administered through Sav-Rx. Eligible members pay a 20% co-payment. Benefits are limited to a 30-day supply for retail purchases. A 90-day supply is available through the mail order program. The mail order co-payments are $5 for a generic drug and $20 for a brand name drug.

Prescription drug expenses are not counted toward any stop-loss limit, and prescription drug expenses are never payable at 100%, even after a covered person has satisfied an otherwise applicable stop-loss limit.

Members are required to use any available and applicable coupons for specialty drugs that are listed in SavRx's High Impact Advocacy (HIA) program so long as the program is available. See Plan Document, Part 4, Section 18.01. For more information on your prescription drug benefits and to better manage your medications, please access the Sav-Rx Patient Portal by visiting: app.savrx.com.

## ORTHOTICS BENEFIT

Benefits are provided to all participants and eligible dependents (whether enrolled in the Kaiser HMO or the Self-Funded PPO Plan) once in a covered person's lifetime. A participant or eligible dependent may receive up to $170 in reimbursement after a $25 co-pay for the cost of orthotics prepared by any provider.

## SMOKING CESSATION BENEFIT

The Plan will reimburse any eligible participant or dependent (whether enrolled in the Kaiser HMO or the Self-Funded PPO Plan) for the costs associated with the successful completion of a smoking cessation behavior modification program, including the cost of classes and smoking cessation aids associated with the classes, up to $300. Proof of expenses and completion of the program must be provided to the Plan Administration Office.

## EMPLOYEE ASSISTANCE PROGRAM

The Plan provides an Employee Assistance Program for all participants and dependents. Benefits are provided through Claremont Behavioral Services (also known as Uprise Health) or through providers under contracts with Claremont Behavioral Services. Contact Claremont at (800) 834-3773 or www.claremonteap.com.

Claremont provides a wide range of counseling and consultation services:

| Service | Description | Quantity |
|---|---|---|
| Clinical Counseling | One-on-one, in-person clinical consultations to assist with personal and/or work-related issues affecting quality of life, including marital/family conflicts, substance abuse, work stress and depression. | *3 consultations per incident per year |
| Legal Consultations | One 30-minute consultation, by telephone or in-person, per issue. Attorneys have expertise in family law, consumer issues, traffic violation, personal injury, etc. A 25% discount is available for any legal services beyond the initial consultation. A "simple will" kit is available. | *1 per issue<br><br>Will kits: 1 per covered person |
| Financial Consultations | One 30-60 minute consultation, by telephone or in-person, per issue, covering budgeting, debt consolidation, retirement planning, financial planning, auto purchases, real estate purchases, etc. Credit reports are available. | *1 per issue<br><br>Credit Reports: 1 per intake year per covered person |

| | | |
|---|---|---|
| Child Care Consultations and Referrals | One telephonic consultation, per issue, to assist with child care and parenting issues; referrals to day care homes, infant centers, pre-schools, before/after school programs, sick/emergency care, in-home options, and care for special needs children. | *1 per issue |
| Elder/Disabled Care Consultations and Referrals | One telephonic consultation, per issue, to assist with elder care and disabled adult issues; referrals to care providers and support services. | *1 per issue |
| Pet Care Referrals | One telephonic consultation per issue; referrals to vets, animal hospitals, pet services, insurance, and obedience classes. | *1 per issue |
| Adoption Assistance | One telephonic consultation, per issue, to assist with adoption options and issues; referrals to adoption agencies and support services. | *1 per issue |
| School and College Selection Assistance | One telephonic consultation, per issue, to assist with school and college selection issues; referrals to public and private elementary and secondary schools, colleges and universities, test preparation courses, financial aid and educational consultants. | *1 per issue |
| Community-Based Resource Referrals | Referrals to community-based resources for assistance with personal or work-related issues affecting quality of life. | *Unlimited |

* No copays apply unless additional consultations are requested.

## ALCOHOL AND DRUG DEPENDENCY TREATMENT

SELF-FUNDED PPO PLAN

Benefits for alcohol and drug dependency treatment and rehabilitation, under the Self-Funded PPO Plan, must be reviewed by the Claremont Behavioral Services Employee Assistance Program, which is the Plan's Preferred Provider Organization (PPO) for alcohol and drug dependency treatment benefits.

Alcohol and drug dependency rehabilitation benefits are available only to bargaining unit employees and their eligible dependents. Medical detoxification benefits are covered as a medically necessary benefit for all participants enrolled in the Self-Funded PPO Plan.

Contact Claremont (also known as Uprise Health) at (800) 834-3773 or www.claremonteap.com.

The following limitations apply to the benefits the Plan will pay, and the patient is responsible for all charges not paid by the Plan:

| Inpatient Benefits - Self-Funded PPO Plan | Plan pays: |
|---|---|
| First confinement, when you use a PPO Provider | 100% |
| Second confinement, when you use a PPO Provider | 90% |
| Any subsequent confinement, when you use a PPO Provider | 90% |
| Any confinement, when you use a Non-PPO Provider | 70% |
| ($200 per confinement deductible applies) | |

| Outpatient Benefits - Self-Funded PPO Plan | |
|---|---|
| When you use a PPO Provider | 100% |
| When you use a Non-PPO Provider | 70% |

| KAISER HMO | You pay: |
|---|---|
| Inpatient Detoxification | No charge |
| Individual outpatient chemical dependency evaluation and treatment | $25 per visit |
| Group outpatient chemical dependency treatment | $5 per visit |

Kaiser provides inpatient medical detoxification benefits to all participants enrolled in Kaiser. Bargaining Unit Participants enrolled in Kaiser also have access to rehabilitation benefits provided by Claremont Behavioral Services dba Uprise Health. Contact Claremont at (800) 834-3773 or www.claremonteap.com.

EXTENDED BENEFIT FOR FORMER BARGAINING UNIT EMPLOYEES (CLASS A PARTICIPANTS) IN THE SELF-FUNDED PLAN OR KAISER

If you are an active employee and lose coverage under the Plan (whether you were enrolled in Kaiser or the Self-Funded PPO Plan), you may be eligible for an Extended Benefit for alcohol and drug dependency detoxification and rehabilitation, under the following rules:

1. You must elect to use the Extended Benefit within 180 days of the date on which your Plan coverage terminates by notifying the Administration Office.

2. Your eligibility for the Extended Benefit will terminate upon the earliest of:

   (a) 180 days after the first day on which you first receive treatment or services under the Extended Benefit;

   (b) the first day of the first month that you are reinstated as a participant in the Plan;

   (c) the effective date of your retirement under the Sign, Pictorial and Display Industry Pension Plan; or

   (d) 180 days after your Plan coverage terminates, if you have not yet elected to use the Extended Benefit.

3. You do not need to elect COBRA Continuation Coverage in order to elect the Extended Benefit.

4. In order for services to be covered, you must use a PPO provider and all benefits must be reviewed by the Claremont Behavioral Services Employee Assistance Program. Inpatient benefits require prior approval by the Claremont Behavioral Services Employee Assistance Program.

| Inpatient benefits are covered as follows: | Plan pays: |
|---|---|
| First confinement | 100% |
| Second confinement | 90% |
| Any subsequent confinement | 90% |

PLEASE NOTE: any prior confinement as an active employee in the Self-Funded PPO Plan is included in determining the inpatient benefits that will be provided under the Extended Benefit.

| | Plan pays: |
|---|---|
| Outpatient benefits | 100% |

5. The Extended Benefit is not available to dependents.

## LIFE INSURANCE

The Plan provides life insurance for active bargaining unit ("Class A") employees and eligible Class B, C and D participants, and their dependents, through group insurance policies purchased from United of Omaha. COBRA participants and retirees are not eligible for life insurance benefits.

The following is a summary of the benefits currently in effect. The complete terms and conditions are stated in the insurance policy issued by United of Omaha. Please note, however, that the terms of the United of Omaha policy may change from time to time, and the actual benefits are determined by the policy in effect at the time of a covered person's death. This summary is not intended to supersede that policy, and any changes to the policy supersede this booklet.

### Benefit Amounts

The following amounts of benefits are payable:

LIFE INSURANCE:
Employee ..... $5,000
Dependent Spouse or Registered Domestic Partner ..... $2,000
Dependent Child (birth to age 21, or to age 25 if a full-time student) ..... $2,000

These benefits are payable if you die, or your covered dependent dies, while eligible for benefits under the Plan. Benefits are also payable under "Continuation of Insurance" provisions for thirty-one days after termination of eligibility, or beyond that if you exercise the Conversion Privilege, or if you qualify for, and comply with the requirements for Waiver of Premium Benefit in the Event of Total Disability.

### Dependent Eligibility

The following are eligible for dependent's life insurance:

1. Your lawful spouse, or your registered domestic partner;

2. Your natural-born child or your adopted child, as defined in the policy;

3. Your stepchild who is living in your home and is chiefly dependent on you for support; and

4. A foster child, as defined in the policy.

The following are not eligible for dependent's life insurance:

1. Your divorced spouse or domestic partner, if the domestic partnership has been dissolved, or any married child;

2. A child who has been legally adopted by another person;

3. Anyone eligible for insurance under the policy as an employee; or

4. A child who has attained the limiting age. The "limiting age" is:

   (a) the child's 21st birthday; or

   (b) the 25th birthday if the child is a full-time student in any accredited high school, trade school, college or university and is chiefly dependent upon you for support.

The insurance for a mentally or physically handicapped child who attains the limiting age while insured under the policy may be continued if the child is chiefly dependent on you for support, and is not capable of self-sustaining employment; provided you give the Plan's Administration Office proof of the child's handicap no later than 31 days after the child attains the limiting age, and thereafter as the insurance carrier may require, but not more often than once every two years.

Dependent's insurance will begin the later of: the day you are insured, or the day you first acquire an eligible dependent.

Dependent's insurance will end at midnight on the earliest of:

1. the last day of the policy month the dependent is no longer eligible;

2. the day any dependent premium is due and unpaid;

3. the day the policy ends;

4. the day before a dependent enters the Armed Forces on active duty (except for temporary active duty of two weeks or less);

5. the day dependents insurance under the policy ends because of lack of participation;

6. the day your insurance is continued without payment of premium (see the Waiver of Premium If You Are Totally Disabled provision); or

7. the day your insurance ends.

**Waiver of Premium If You Are *Totally* Disabled**

If you become totally disabled, and your life insurance coverage will end because you are retired, on COBRA, or your extended disability coverage has run out, your life insurance will be continued without payment of any premium until you reach age 65 if 1) your disability began while you were covered for life insurance, 2) your disability began before you reached age 60, and 3) you provide proof of disability as described below.

You must notify United of Omaha of your total disability not later than the 9th through the 12th month of your disability. You and your physician will then be required to submit proof of your disability. If accepted, your life insurance will be continued for a period of one year. Thereafter, you and your physician must submit proof again each year that you are totally disabled. Your proof of disability must be submitted annually during the 3-month period before each anniversary of receipt of your initial proof, in order for your life insurance to be continued for another year.

If you die before you submit proof of total disability, benefits will still be payable provided:

(a) your death was within 12 months from the day insurance would have otherwise ended under the policy; and

(b) United of Omaha receives proof that your total disability was uninterrupted from the date insurance would otherwise have ended until your death.

Your life insurance will not be continued beyond the date you are no longer totally disabled. When your total disability ends, you have 31 days to convert your coverage to an individual policy under the Conversion Privilege rules below, but you may not convert if you again become insured under the policy.

**Conversion Privilege**

If your employment ends, or your membership in Class A or C ends, you may apply for an individual life insurance policy (called a conversion policy) without giving information about your health, provided you apply within 31 days of the date your group life insurance coverage ends. You may apply for any available individual life insurance policy except term insurance; the amount of the conversion policy may not exceed the amount of the terminated group insurance policy; and the premium for the policy will be at the standard rate for such policies based upon your class of risk and your age when the policy takes effect.

If your group life Insurance ends because of termination of the policy or termination of a class, and you have been insured under the policy for at least five years, you may apply for a conversion policy, provided you apply within 31 days of the date your group life insurance coverage ends. You may apply for any available individual life insurance policy except term insurance; and the premium for the policy will be at the standard rate for such policies based upon your class of risk and your age when the policy takes effect. The amount of the conversion policy may not exceed the lesser of:

(a) $3,000.00; or

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

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

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

(a) you terminate the conversion policy; or

(b) you submit, at your own expense, evidence of good health acceptable to United of Omaha.

If your spouse's or domestic partner's life insurance ends because of your death; under circumstances where you have the right of conversion; or because your life insurance is being continued under the Waiver of Premium If You Become Totally Disabled provision, your spouse or domestic partner may apply for a conversion policy within 31 days of the date his or her life insurance coverage ends. Your spouse or domestic partner may apply for any available individual life insurance policy except term insurance; the amount of the conversion policy may not exceed the amount of the terminated group insurance policy; and the premium for the policy will be at the standard rate for such policies based upon your spouse's or domestic partner's class of risk and age when the policy takes effect.

**Beneficiary for Life Insurance**

You may designate anyone, or any number of people, to be your beneficiary for your life insurance benefit. **Be sure to fill out a beneficiary card and keep it current.**

If there is no designated beneficiary, your benefits will be paid:

(a) to your surviving spouse; if none, then

(b) to your surviving natural and/or adopted children; if none, then

(c) to your surviving parent(s); if none, then

(d) to your estate.

Benefits will be paid equally among surviving children or surviving parents.

You are automatically the beneficiary for life insurance on your dependents, if you are living. If you are not living, the following will apply:

1. If your spouse or registered domestic partner dies, benefits will be paid to the spouse's or domestic partner's estate.

2. If a child dies, benefits will be paid to your spouse, if your spouse is living. If your spouse is not living, benefits will be paid in equal shares to the child's surviving brothers and sisters. If none survive, benefits will be paid to the estate of the deceased child.

Any benefits payable to a minor in accord with the above paragraph may be paid to the legally appointed guardian of the minor. If there is no legally appointed guardian, payment may be made up to $50.00 a month to the adult or adults who, in United of Omaha's opinion, have assumed custody and principal support of the minor.

If a dependent dies within 31 days from the day the dependent's life insurance is terminated, United of Omaha will still pay the amount for which the dependent was last insured, upon receipt of proof within one year after death.

Please note that the designation of beneficiary for Life Insurance under this Benefit Plan is a different designation from the designation you may have made under the pension plan or under other death benefits available through the Local Union. If you want to check on your designation of beneficiary under this Plan, or change your designation of beneficiary, contact the Plan Administration Office.

**Facility of Payment**

United of Omaha may pay up to $500 to any person who has incurred expenses for your fatal illness or burial.

**How to File a Claim for Life Insurance**

You may request claim forms for life insurance benefits from the Local Union or the Plan Administration Office. Complete the form and send it, with an original certified death certificate, to the Plan Administration Office. Your claim form should be received by the Plan Administration Office within 90 days from the date of loss, if possible, or otherwise as soon as possible. **To avoid missing the claim deadline, file your claim as soon as possible.**

## CLAIMS AND APPEALS PROCEDURES

### How to Submit Claim Forms for Benefits

Medical:

Self-Funded PPO Plan: Your provider should submit claims to the Blue Shield of California Claims Office, P.O. Box 272540, Chico, CA 95927. Your provider may also submit claims electronically through Blue Shield's secure electronic data interchange (EDI) system. If your provider is able to submit claims electronically, he or she should contact Blue Shield directly. Note that claims must be submitted within 12 months of the date of service, or they will be denied.

Kaiser: No claims forms are required for medical, hospital, and surgical benefits if you are covered under the Kaiser HMO plan. Simply present your Kaiser card whenever you receive services, and make the applicable co-payment.

Dental: Your dentist should submit claims directly to BeneSys Administrators as follows:

**Claims Mailing Address:**
Sign, Pictorial & Display Industry Benefit Plan
PO Box 1618
San Ramon, CA 94583

Your provider may also submit claims electronically through BeneSys's secure electronic data interchange (EDI) system. BeneSys's EDI number is 38238. If your provider is able to submit claims electronically, simply give this number to your provider.

Vision: If you use a VSP participating panel provider, he or she will file claims directly with VSP. You just pay any excess charges for non-covered features. If you use a non-panel provider for vision care, pay the entire bill yourself and submit a claim to VSP for reimbursement of the allowable amount.

Life Insurance: Claim forms are available from the Plan Administration Office and should be submitted to them, with supporting documents.

### Claims and Appeals

The Plan provides for claims and appeals to the Board of Trustees for any matter within their discretion. These procedures apply in the following situations:

- Claims and appeals regarding Plan eligibility for any type of benefit;

- Appeals regarding medical, dental or vision benefits when the claimant has made a specific claim to Kaiser, and Kaiser has denied the claim on the grounds that the participant or family member is not eligible for benefits under the rules of the Plan.

- All appeals under the Self-Funded PPO Plan.

You may appeal any adverse action with regards to compliance with the surprise billing protections under the No Suprises Act to Blue Shield of California Claims Office.

You or your health care provider may file a claim for benefits by contacting the Plan Administration Office. Written proof of claim must be sent to the Plan Administration Office or the Board of Trustees no later than 12 months following the date of service. A claim submitted more than 12 months after the date of service will be denied, except for a claim that is timely under either the specific terms of a network provider agreement with this Plan, or pursuant to applicable federal laws and regulations.

The Plan Administration Office will notify you of its determination within the following deadlines, unless it notifies you that it needs more information or an extension:
- Urgent Care: 72 hours
- Non-Urgent Care: 15 days
- If you have already received the care: 30 days

If you disagree with the determination of the Plan Administration Office, you may appeal to the Board of Trustees by sending a letter to the Plan Administration Office, within 180 days of receiving the denial of benefits. The Board of Trustees will conduct an independent review of your appeal. **Failure to appeal a determination of the Plan Administration Office within the time allowed is deemed a waiver of all objections to that determination.**

The Plan Administration Office will notify you in writing of the Trustees' decision before the following deadlines, unless they notify you that they need more information or an extension:
- Urgent Care: 72 hours
- Non-Urgent Care: 30 days
- If you have already received the care: 5 days after the next regularly scheduled meeting of the Board of Trustees, unless the appeal is filed less than 30 days before the next meeting, in which case you will be notified 5 days after the second meeting of the Board of Trustees.

The Board of Trustees will authorize a hearing only if the Board determines that a hearing would be of assistance in its deliberation. These procedures are the only procedures you may use to appeal an adverse action taken by the Board of Trustees or other Plan fiduciary or agent. For full claims and appeal procedures and rules, see Plan Document, Part 1, Section 10.

A civil action based on a claim denial must be filed within one year of the Board of Trustees' denial of your appeal.

Appeals to Kaiser: The Board of Trustees does not hear appeals regarding adverse actions taken by Kaiser, except if the grounds is your eligibility for benefits under the Plan. If a claim for Plan benefits is denied by Kaiser on grounds other than eligibility under Plan rules, such as medical necessity, a participant or provider may appeal directly to Kaiser, and that is the only available appeal. The appeal procedures of Kaiser are set forth in Kaiser's Evidence of Coverage documents. Please call the Plan Administration Office to obtain a copy of these documents.

## ADMINISTRATIVE INFORMATION

| | |
|---|---|
| Name of Plan: | Sign, Pictorial & Display Industry Benefit Plan |
| Employer Identification No. | 94-6087594 |
| Plan Number: | 501 |
| Plan Year: | January 1 to December 31 |

PLAN ADMINISTRATOR:
The Plans are administered by a joint Board of Trustees consisting of four employee trustees appointed by the Sign Industry Local No. 510 and four employer trustees. The mailing address and contact information for the Board of Trustees are as follows:

Board of Trustees, Sign, Pictorial & Display Industry Benefit Plan
BeneSys Administrators
7180 Koll Center Parkway, Suite 200, Pleasanton, CA 94566
Telephone: (925) 398-7048
Website: www.ourbenefitoffice.com/Sign510/Benefits/

The members of the Board of Trustees are:

Employee Trustees

Mr. Morgan Worth
Local No. 510
400 Talbert
Daly City, CA 94014

Mr. Luis Robles District Council 36
1155 Corporate Center Drive
Monterey Park, CA 91754-7604

Ms. Annette Dosier
Local No. 510
400 Talbert
Daly City, CA 94014

Mr. Jon Coley District Council No. 36
1155 Corporate Center Drive
Monterey Park, CA 91754-7604

Employer Trustees

Mr. Bill Kuehnle
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Mr. John Sauter
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Mr. Richard Hill
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Ms. Nancy Horner
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

Mr. Jann Laragan (Alternate Trustee)
7180 Koll Center Parkway, Suite 200
Pleasanton, CA 94566

The Benefit Consultant is Rael & Letson, 160 Bovet Road, Suite 203, San Mateo, CA 94402

TYPE OF ADMINISTRATION:

The Board of Trustees is assisted in the administration of the Plan by a contract administrator, BeneSys Administrators, at the address and phone number listed above. Certain benefits are provided through contracts of insurance, administrative services contracts, or health service plans, as described above. The Board is also assisted in the administration of the Plan by Sign, Display & Allied Crafts Local Union No. 510, whose address appears below.

The Sign, Pictorial & Display Industry Benefit Plan is a self-funded plan, except for life insurance. It contracts with Standard Security Life Insurance Company of New York for Stop Loss Coverage. The Board of Trustees has also hired a health maintenance organization and other providers to provide benefits or claims services under insurance contracts or service agreements. Their names and phone numbers appear on page 2 above.

AMENDMENT AND TERMINATION OF PLAN AND/OR TRUST FUND
Although there is no intention or expectation that this would occur, the collective bargaining parties have the power to terminate all contributions to the Plan. If this occurs, the funds already contributed shall be applied by the Board of Trustees, in their discretion, to provide benefits to covered individuals, either through the existing Trust Fund or through other collectively bargained plans offering similar benefits to employees working in the Sign, Pictorial & Display Industry. In no event shall the termination of the Plan cause any contributions to revert to an employer.

AGENT FOR SERVICE OF LEGAL PROCESS:
Raphael Shannon Kraw
Kraw Law Group
605 Ellis Street, Suite 200
Mountain View, CA 94043
(650) 314-7815

Service of legal process may also be made upon any of the Trustees, at his or her regular place of business, or on BeneSys Administrators.

FUNDING AND PLAN SPONSORSHIP:
This Plan is funded by contributions made pursuant to collective bargaining

agreements between Sign, Display & Allied Crafts Local Union No. 510, International Union of Painters and Allied Trades, and employers in the outdoor advertising, pictorial, commercial sign, graphics production, exhibit display, trade show and convention construction and decorating industry. A complete list of employers, employer associations, and labor organizations sponsoring the Plan may be obtained by participants and beneficiaries upon written request to the Plan Administration Office, subject to payment of a reasonable copying charge, and is also available for examination by participants and beneficiaries upon reasonable notice. A participant or beneficiary may also request information as to whether a particular employer, employer association, or labor organization is a sponsor of the Plan, and if so, the sponsor's address. Copies of collective bargaining agreements may be obtained by participants and beneficiaries upon written request to the Plan Administration Office, subject to payment of a reasonable copying charge, and are available for examination by participants and beneficiaries, upon reasonable notice.

The Board of Trustees employs Verus as its investment consultant. The Plan's reserves assets are currently invested in the Vanguard 500 Index (VFIAX), the Vanguard FTSE World Ex-US Index (VFWSX), the Baird Short Term Bond Fund (BSBIX), the PIMCO Income Fund (PIMIX), the TCW MetWest Total Return Bond Fund (MWTSX) and the First American Government Obligations Fund (FUZXX).

The following organization is party to the Master Labor Agreement under which this Plan is maintained:

Labor Organization

Painters & Allied Trades District Council 36
1155 Corporate Center Drive,
Monterey Park, CA 91754
on behalf of:
Sign, Display & Allied Crafts Local Union No. 510
400 Talbert
Daly City, CA 94014

## YOUR RIGHTS UNDER ERISA

As a participant in the Sign, Pictorial & Display Industry Benefit Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants are entitled to:

Receive Information About Your Plan and Benefits

Examine, without charge, at the Plan Administration Office and at other specified locations, such as worksites and union halls, all documents governing the plan, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

Obtain, upon written request to the Plan Administration Office, copies of documents governing the operation of the plan, including insurance contracts and collective bargaining agreements, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Plan Administration Office may make a reasonable charge for the copies.

Receive a summary of the plan's annual financial report. The Plan Administration Office is required by law to furnish each participant with a copy of this summary annual report.

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 health and welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a health and 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. (See page 47 and Plan Document, Part 1, Section 10, for the Plan's claims and appeals procedures.)

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, you may file suit in federal court, although your right to sue may be limited if you have not used the Plan's appeal procedures. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Plan Administration Office. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the plan administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, which is the San Francisco Regional Office, 90 Seventh Street, Suite 11-300, San Francisco, CA 94103, Telephone: (415) 625-2481, 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.