OFFICE & PROFESSIONAL EMPLOYEES

INTERNATIONAL UNION LOCALS 30 & 537

HEALTH & WELFARE FUND

SUMMARY PLAN DESCRIPTION

REVISED EFFECTIVE NOVEMBER 1, 2022

To All Plan Participants:

We are pleased to provide you with this new booklet which describes the Fund's eligibility rules and benefits for active members and their families. This booklet includes all changes made through November 1, 2022. **Please review this booklet thoroughly to familiarize yourself with the latest changes.**

This booklet contains descriptions of all the benefits provided by the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund except for health benefits under the Kaiser Foundation Health Plan and dental benefits through United Concordia. Benefit programs under Kaiser and United Concordia are explained in separate booklets issued by these organizations.

We hope that these benefits will protect you and your family members if any of you suffer illness or injury. We also hope that you will use your health benefits intelligently, taking advantage of the preferred provider discounts through AETNA and follow the rules requiring pre-certification of hospital stays and other cost containment features. By doing so, you will qualify for maximum benefits. At the same time, you will help the Fund operate in the most cost-effective way possible.

In the pages that follow you will find a summary of benefits, the rules covering eligibility for those benefits, and the procedures that should be followed when making a claim. Contained in the back of the booklet is additional information about the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund as required by law. We also encourage you to visit the Trust website at www.opeiufunds.org.

Only the Board of Trustees is authorized to interpret the rules and regulations described in this booklet. No individual Trustee, union representative, or employer representative is authorized to interpret the rules and regulations on behalf of the Board or to function as an agent of the Board.

The Board of Trustees has authorized the Plan Administrator to respond in writing to written inquiries from Fund Participants. As a convenience to you, the Plan Administrator may provide oral answers regarding coverage on an informal basis. However, no such oral communication is binding on the Board of Trustees.

Again, we strongly suggest that you read the entire contents of this booklet so that you will be familiar with the comprehensive protection the Fund provides you and your family. You may call the Plan Administrator at (562) 463-5065 or (800) 386-4350 should you have any questions.

THE BENEFITS SUMMARIZED MAY OR MAY NOT WHOLLY APPLY TO YOU SINCE THE AGREEMENT BETWEEN YOUR EMPLOYER AND THE UNION MAY PROVIDE FOR ALL OR JUST SOME OF THE BENEFITS DESCRIBED.

Sincerely,

THE BOARD OF TRUSTEES

INTRODUCTION

This Fund was established as a result of collective bargaining between representatives of your Employer and Office and Professional Employees International Union Local 30 and Local 537. Contributions are paid by your Employer into a Trust Fund to provide Medical, Surgical, Hospital, Dental, Prescription Drug, Life and AD&D insurance and Vision Benefits for employees and their dependents.

HOWEVER, THE AGREEMENT BETWEEN YOUR EMPLOYER AND THE UNION MAY PROVIDE FOR ALL OR JUST SOME OF THE BENEFITS LISTED HEREIN.

The Board of Trustees determines policies and benefits in keeping with the assets and income of the Office and Professional Employees Locals 30 & 537 Health and Welfare Trust Fund. Benefits are subject to all the terms and conditions of the Trust Agreement as well as to any rules and regulations the Trustees may adopt from time to time.

This booklet describes how you and your dependents may use these Benefits to the best advantage, when you are eligible. Please read it carefully and if you have any questions, contact the Trust Fund Office. The effective date of this booklet is November 1, 2022, and it replaces all prior Summary Plan Descriptions, benefit summaries and Summaries of Material Modification issued prior to that date.

Foreign Language Notice
This booklet contains a summary in English of your rights and benefits under the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund. If you have any difficulty in understanding any part of this booklet, you may contact Benefit Programs Administration, 1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906, telephone number (562) 463-5065 or (800) 386-4350.

Aviso En Español
Este folleto contiene un resumen en ingles de sus derechos y beneficios bajo el O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund. Si tiene alguna dificultad en comprender cualquier parte de este folleto, puede comunicarse con Benefit Programs Administration, 1200 Wilshire Blvd., Fifth Floor, Los Angeles, CA 90017-1906, o llamar a los teléfonos (562) 463-5065 o (800) 386-4350.

IMPORTANT NOTICE TO EMPLOYEES, SPOUSES AND DEPENDENTS

From time to time the Trust Fund Office may mail you updated materials in order to inform you and your dependents of any changes in benefits. It is important that you file all literature received in the back of this booklet and note the affected sections.

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

1. To take all actions and make all decisions with respect to the eligibility for, and the amount of, benefits payable under the Plan.

2. To formulate, interpret and apply rules, and policies necessary to administer the Plan in accordance with its terms.

3. To decide questions, including legal or factual questions, relating to the calculation and payment of benefits under the Plan.

4. To resolve and/or clarify any ambiguities, inconsistencies and/or omissions arising under the Plan or other Plan documents; and

5. To process, and approve or deny, benefit claims and rule on any benefit exclusions.

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

IMPORTANT PHONE NUMBERS

In many cases, you will receive better health benefits from the Plan if you make informed decisions. If you have any questions about how to use the Plan, contact the Trust Fund Office for assistance. Important phone numbers and websites are listed below.

For general information about the Plan or for information about eligibility, benefits, or claims:

Plan Administrator/Trust Fund Office (BPA)
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5065 or
(800) 386-4350
www.opeiufunds.org

For information about Major Medical Preferred Plan Organization (PPO) Provider Services and pre-Admission Review:

AETNA
(888) 632-3862
www.aetna.com

In case of a Major Medical Plan emergency admission (a call must be made within 24 hours of the emergency admission):

AETNA
(888) 632-3862
www.aetna.com

For information about Kaiser HMO medical, prescription drug or vision benefits or provider locations:

Kaiser Foundation Health Plan, Inc.
(800) 464-4000
www.kp.org

For information about the vision program for Major Medical Plan participants:

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

For information about the Prescription Drug plan for Major Medical Plan participants:

Express Scripts
(800) 451-6245
www.express-scripts.com

For information about the Pre-Paid Dental plan:

United Concordia
(866) 357-3304
www.unitedconcordia.com

For information about the life and AD&D insurance carrier:

UnitedHealthcare
(866) 302-4480
www.myuhc.com

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USING YOUR HEALTH PLAN

The plan of medical benefits available through the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund allows the covered employee to choose, once each year, coverage under the Major Medical Plan, which allows you free choice of any physician you wish, or the Kaiser Foundation Health Plan, which provides full medical care for you and your dependents at any of its facilities.

If you choose to be covered under the Major Medical Plan, the Fund has contracted with a panel of physicians and hospitals through AETNA Choice POS II Plan which provide substantially increased benefits to you and your dependents. Please keep in mind that you have a choice of doctors and hospitals at all times. You will, however, save substantial out-of-pocket expenses by utilizing the AETNA panel of PPO providers.

It is important to note that even if you are utilizing the services of an AETNA PPO hospital, increased coverage for any physician charge is only available if the physician (including the assistant surgeon and anesthesiologist) is also a member of the AETNA PPO.

A summary of the Major Medical Plan (both PPO and non-PPO) and Kaiser medical benefits available to you follows. A more detailed description of the benefits available to you under the Major Medical Plan is included in this booklet. Please be sure to thoroughly review the Major Medical Plan's cost containment programs administered by AETNA starting on page 59. A separate brochure is available which describes the medical, prescription drug and vision benefits under the Kaiser Foundation Health Plan.

An option is also available to you for dental coverage. A description of the dental benefits under the "Basic Dental Plan" is included in this booklet. This option allows you to use the services of any licensed dentist. A separate brochure is available which describes greater coverage under the pre-paid dental option through United Concordia.

SPECIAL NOTICE TO KAISER ENROLLEES

Enclosed in this booklet is a brief summary of the medical, prescription drug and vision benefit coverage afforded to you and your dependents, if eligible. It is important to note that it is in summary form only and it does not completely describe your benefit coverage. For details on your Kaiser coverage, please refer to the Kaiser Foundation Health Plan, Inc., Evidence of Coverage. The Evidence of Coverage is the binding document between the Kaiser Foundation Health Plan, Inc., and its members (or enrollees). A Kaiser Health Plan physician must determine that the services and supplies are medically necessary to prevent, diagnose or treat your medical condition. The services and supplies must be provided, prescribed, authorized, or directed by a Kaiser Health Plan physician. You must receive the services and supplies at a Kaiser Health Plan facility or skilled nursing facility inside the Kaiser Service Area, except where specifically noted to the contrary in the Kaiser Health Plan Evidence of Coverage. For details on the benefit and claims review and adjudication procedures, please refer to the Kaiser Health Plan Evidence of Coverage. If there are any discrepancies between benefits provided in the summary and the Kaiser Health Plan Evidence of Coverage, the Kaiser Health Plan Evidence of Coverage will prevail.

SPECIAL NOTICE TO UNITED CONCORDIA ENROLLEES

For details on your benefit coverage, please refer to the United Concordia Evidence of Coverage. The United Concordia Evidence of Coverage is the binding document between United Concordia and its members (or enrollees). A provider in the United Concordia network must determine that the services and supplies are necessary to prevent, diagnose or treat your dental condition. The services and supplies must be provided, prescribed, authorized, or directed by a provider in the United Concordia network. You must receive the services and supplies at an office within the United Concordia network of providers unless noted to the contrary in the United Concordia Evidence of Coverage. For details on the benefit and claims review and adjudication procedures, please refer to the United Concordia Evidence of Coverage. If there are any discrepancies between information provided herein and the United Concordia Evidence of Coverage, the United Concordia Evidence of Coverage will prevail.

SUMMARY OF HEALTH PLANS

	O.P.E.I.U. LOCALS 30 & 537 MAJOR MEDICAL PLAN		
COVERAGE AND TERMS	**NON-PPO COVERAGE**	**AETNA PPO** Must Utilize Participating AETNA Choice POS II Hospitals & Providers	**KAISER Permanente**
Explanation of Plans and Options Available to you:	You may use the doctor of your choice. When your claim is received, it is processed (subject to the Annual Deductible) under the Major Medical Benefits shown below in this column but subject to the Plan's Limitations and Exclusions.	May be used by participants covered under the Major Medical Plan at their option at any time. If an AETNA Choice POS II Provider is used, the benefits shown below will apply SUBJECT TO THE ANNUAL PLAN DEDUCTIBLE AND MAJOR MEDICAL PLAN LIMITATIONS AND EXCLUSIONS.	For benefits through this plan, you must use KAISER physicians and facilities.
INDIVIDUAL DEDUCTIBLE (Calendar Year)	$700 per person per calendar year; Maximum $2,100 per family.	$350 per person per calendar year; Maximum $1,050 per family.	None
OUT-OF-POCKET MAXIMUM	When a participant incurs $4,000 out of pocket for covered medical plan expenses during any calendar year; coverage will increase to 100%. Non-PPO hospital charges do not apply.	When a participant incurs $4,300 out of pocket for covered medical plan expenses ($8,600 per family) during any calendar year, coverage will increase to 100%.	$3,000 ($6,000 per family)
ANNUAL MAXIMUM	None	None	None
HOSPITAL IN-PATIENT CARE:(Room accommodation on all options is *Semiprivate*.)	NOTE: PRE-NOTIFICATION PRIOR TO ANY *NON-EMERGENCY* HOSPITAL ADMIT IS REQUIRED; CALL 1-888-632-3862 – 30% PENALTY FOR NON-COMPLIANCE.	NOTE: PRE-NOTIFICATION PRIOR TO ANY *NON-EMERGENCY* HOSPITAL ADMIT IS REQUIRED; Call 1-888-632-3862 – 30% PENALTY FOR NON-COMPLIANCE.	AT KAISER HOSPITALS ONLY – $500 per Admission Co-payment
Room and Board	60% – Semi-Private Room Rate	80% – Semi-Private Room Rate	
Intensive Care; C.C.U.	60% – Max 2.5 x Semi-Private Room Rate	80% – Max 2.5 x Semi-Private Room Rate	
Misc. Hospital Charges	60%	80%	
EMERGENCY ROOM	80%	80%	$50 co-payment per visit (waived if admitted)
SKILLED NURSING FACILITY (Licensed)	60% – Limited Benefits	80% – Limited Benefits	100% – up to 100 days per year
OUTPATIENT FACILITY CHARGES	60%	80%	$40 co-payment per procedure
AMBULANCE	60% of Usual, Customary and Reasonable charges (UCR)	60%	No charge within service area
SURGICAL BENEFITS:	PRE-NOTIFICATION REQUIRED ON CERTAIN ELECTIVE SURGERIES; CALL 1-888-632-3862 – 30% PENALTY FOR NON-COMPLIANCE.	PRE-NOTIFICATION REQUIRED ON CERTAIN ELECTIVE SURGERIES; CALL 1-888-632-3862 – 30% PENALTY FOR NON-COMPLIANCE.	THROUGH KAISER PHYSICIANS ONLY
Surgeon	60% UCR	80%	$40 outpatient co-payment, $0 in-patient co-payment
Assistant Surgeon	60% UCR (up to 20% of Surgery charges, subject to medical necessity)	80% (up to 20% of Surgery charges, subject to medical necessity)	100% – YOU PAY NOTHING
Anesthetist	60% UCR	80%	100% – YOU PAY NOTHING

	O.P.E.I.U. LOCALS 30 & 537 MAJOR MEDICAL PLAN		
COVERAGE AND TERMS	**NON-PPO COVERAGE**	**AETNA PPO** Must Utilize Participating AETNA Choice POS II Hospitals & Providers	**KAISER Permanente**
PHYSICIAN'S VISITS – IN HOSPITAL	60% UCR	80%	100% – YOU PAY NOTHING
PHYSICIAN'S CARE – IN OFFICE	60% UCR	80%	$40 co-payment per visit
Referred to Specialist	60% UCR	80%	
Injectable Medications	60% UCR	80%	
Radiation Therapy	60% UCR	80%	
Physical Therapy	60% UCR – 30 visit maximum per calendar year per illness.	80% – 30 visit maximum per calendar year per illness.	$40 co-payment per visit
X-Ray and Laboratory	60% UCR – Certain Diagnostic tests must be pre-authorized. Call 1-888-632-3862 – 30% penalty for non-compliance.	80% – Certain Diagnostic tests must be pre-authorized; Call 1-888-632-3862 – 30% penalty for non-compliance.	
Podiatry	60% UCR – 10 visits per calendar year.	80% – 10 visits per calendar year.	$40 co-payment per visit
Allergy Testing	60% UCR	80%	$40 co-payment. One specialty office visit copayment will be charged if the member receives both an allergy consultation and testing during a single appointment.
Preventive Care (as recommended by U.S. Preventative Services Task Force)	60% UCR	100%	100% YOU PAY NOTHING
IN/OUTPATIENT PSYCHIATRIC CARE	60%	80%	Inpatient: $500 per admission Individual outpatient mental health: $40 per visit evaluation and treatment Group outpatient mental health treatment: $20 per visit
FAMILY PLANNING: Maternity, abortion, and sterilizations	Covered as any illness (member/spouse only).	Covered as any illness (member/spouse only).	$40 co-payment per individual outpatient visit, $20 for group visits ($0 for inpatient)
ANNUAL HEALTH ASSESSMENT	60% of UCR	100%	$0 co-payment
PRESCRIPTION DRUGS	Through Express Scripts you pay $20 for generic and $30 for brand name prescriptions (limitation of 100 units or one month supply). 90-day supply available through Express Scripts mail order program at $40 for generic and $60 for brand name. Covered prescriptions purchased through a non-participating pharmacy will be paid at 60% after the $700 non-PPO Major Medical deductible is satisfied. Out of Pocket Calendar Year limit: In-Network Express Scripts prescription drug providers – $3,050 per person / $6,100 Family Calendar Year Out of Pocket Limit Out of Network is subject to $4,000 per person/Calendar Year		You pay $15 for generics and $30 for brand name drugs. (Up to a 100-day supply)

	O.P.E.I.U. LOCALS 30 & 537 MAJOR MEDICAL PLAN		
COVERAGE AND TERMS	**NON-PPO COVERAGE**	**AETNA PPO** Must Utilize Participating AETNA Choice POS II Hospitals & Providers	**KAISER Permanente**
DURABLE MEDICAL EQUIPMENT	60% UCR – up to purchase price.	80% – up to purchase price.	Covered according to Kaiser formulary – No co-payment
VISION BENEFITS	Through Vision Service Plan (VSP) with a $25 co-payment for exam and an additional $50 if frames and/or lenses are ordered. Exam – Once every 12 months. Lenses – Once every 24 months Frames – Once every 24 months		Kaiser Facilities provide Vision Care, $40 co-payment for eye exam Lenses – Once every 24 months. Frames – Once every 24 months. An allowance of up to $150 will be applied towards lenses and frames (or contact lenses).

UCR – Usual, customary, and reasonable as determined by the Plan.

THE ABOVE INFORMATION IS A SUMMARY OF THE PLANS CURRENTLY OFFERED AND IS NOT INTENDED TO REPRESENT A FULL DESCRIPTION OF THE BENEFITS, COVERAGES, LIMITATIONS AND EXCLUSIONS OF THE PLAN.

SCHEDULE OF BENEFITS

EMPLOYEE AND DEPENDENT MEDICAL BENEFITS	Non-PPO	AETNA Choice POS II
Deductible, per person per calendar year	$700	$350
Maximum deductible per family (Deductibles do not apply to Annual Health Assessments, mammograms, immunizations, or inoculations.)	$2,100	$1,050
Out-of-Pocket Medical Plan Maximums		
Per Person	$4,000[1]	$4,300[2]
Family Maximum	N/A	$8,600[2]
Medical Benefit Annual Maximum	Unlimited	
Hospital Daily Benefit for Room and Board	60% of Semi-Private rate	80% of Semi-Private rate
Intensive or Coronary Care	60% of 2½ times Semi-Private rate	80% of 2½ times Semi-Private rate
Miscellaneous Hospital Charges	60% of usual & customary charges	80%
Emergency Room Charges	80%	80%

NOTE: PRE-NOTIFICATION PRIOR TO ANY *NON-EMERGENCY* HOSPITAL ADMIT OR SURGERY IS REQUIRED. TO AVOID A 30% REDUCTION IN COVERAGE, YOU MUST COMPLY WITH THE PROVISIONS DESCRIBED IN THE COST CONTAINMENT PROGRAMS SECTION STARTING ON PAGE 59.

Extended Care or Skilled Nursing Facility Daily Rate (60 days maximum)
60% (80% if a PPO provider) of the amount of Covered Expense incurred, *but not to exceed* 50% of the average semi-private room and board rate for hospitals in the area in which the convalescent hospital is located.

Major Medical Benefits (described on pages 50 through 58)
The Major Medical Benefits cover much of the cost of medical expense. Covered expenses include cost of doctors' visits, nursing care, x-rays, laboratory tests, surgery, and many other kinds of medical services and supplies.

	Non-PPO	AETNA Choice POS II
Percentage Payable	60% of usual & customary charges	80%
Preventive care, screenings and immunizations as recommended by the U.S. Preventative Services Taskforce	60% of usual & customary charges	100%[3]

In emergency situations only, non-PPO hospital charges will be paid at PPO coverage percentages until the patient can be safely transferred to a PPO hospital. The cost of the transfer will be paid at 100% of usual, customary, and reasonable charges. If, after the condition of the patient is stabilized and the patient does not wish to be transferred to a PPO hospital, the Major Medical Plan will pay according to the non-PPO percent coverage.

1 Non-PPO hospital charges do not apply.
2 Includes deductible.
3 Deductible does not apply.

EMPLOYEE AND DEPENDENT BASIC DENTAL PLAN EXPENSE BENEFITS

Annual Deductible	$50
Percentage Payable (of Maximum Fee Allowance) including Covered Dental Expense incurred on account of Orthodontics	
Diagnostic and Preventive	90%
Basic Benefits (*i.e.*, fillings and oral surgery)	80%
Major Services (*i.e.*, crowns, bridges, and dentures)	80%

Pre-certification is suggested when services are expected to exceed $500 (see page 63).

Maximum Dental Amount Per Covered Individual

Dental Expenses (calendar year maximum)	$2,200[1]
Orthodontics (lifetime maximum)	$2,200[2]

EMPLOYEE AND DEPENDENT PRESCRIPTION DRUG BENEFITS - THROUGH EXPRESS SCRIPTS

Copayment Amount ..... $20 for generics/$30 for brand name prescriptions filled at a participating Express Scripts Pharmacy. Mail service program copayments are $40 for generics and $60 for brand names. Maximum out-of-pocket expenses per calendar year: $3,050 per person and $6,100 per family.

NOTE: Reimbursement will be limited to the cost of a generic if a generic is available when a brand name drug is dispensed unless the physician indicates "dispense as written (DAW)" on the prescription. Prescriptions not purchased using Express Scripts will be reimbursed at 60% of reasonable charges, subject to the $700 non-PPO Major Medical Plan deductible.

SUPPLY LIMITATION

Retail Program	30 Days
Mail Service Program	90 Days

EMPLOYEE AND DEPENDENT VISION CARE BENEFITS - THROUGH VISION SERVICE PLAN NETWORK OF OPTOMETRISTS AND OPHTHALMOLOGISTS

Copayment Amounts	$25 for exam $50 for materials
Vision Exam	Every 12 months
Lenses	Every 24 months
Frames	Every 24 months

Limited benefits available from out-of-network providers.

EMPLOYEE ONLY LIFE INSURANCE BENEFITS	**AMOUNT**
Death Benefit	$12,500
Accidental Death and Dismemberment (Additional)	$12,500

[1] Maximum does not apply to children under the age of 19.

[2] Maximum applies to children under the age of 19 if treatment is considered cosmetic and not medically necessary.

PREFERRED PROVIDER ORGANIZATION (PPO) PROVIDER - (AETNA CHOICE POS II PLAN)

The Major Medical Plan maintains an agreement with AETNA providing for "Preferred Provider" rates for physician services and medical facilities. Because AETNA providers have agreed to accept contractual rates, you benefit directly when you use AETNA Choice POS II facilities and physicians.

Covered expenses are paid at 80% for AETNA PPO medical facilities and physician charges (compared to 60% of usual, customary, and reasonable charges for non-PPO providers).

For a list of AETNA Choice POS II PPO physicians and network hospitals, please call the Trust Fund Office at (562) 463-5065. You may also visit the AETNA website at www.aetna.com/docfind.

The list of PPO providers is subject to change. Before your initial appointment with a physician listed in the AETNA directory, please call AETNA to make sure that the physician is still an AETNA provider.

Use of an AETNA PPO provider does not in itself guarantee eligibility or covered benefits. You must always maintain eligibility according to the Eligibility Rules starting on page 26 to be covered. Charges will only be paid for an eligible employee or dependent if the benefit is covered (see pages 50 through 54) and not limited or excluded (see pages 55 through 58).

Effective July 1, 2022, the AETNA website will contain a link to machine readable files populated with the “in-network rate” and “allowed amount” data for “out-of-network” services.

Effective January 1, 2023, Aetna will make a cost estimator tool (the “Tool”) available to Plan Participants for the 500 shoppable services identified by the U.S. Department of Labor. The Tool allows an individual enrolled in the AETNA PPO plan to compare the amount of cost-sharing that the individual would be responsible for paying with respect to the furnishing of a specific item or service by any provider in the PPO Network. Beginning January 1, 2024, the Tool will allow covered individuals to compare the amount of cost-sharing for all covered items and services.

CLAIMS AND APPEAL PROCEDURES FOR MAJOR MEDICAL PLAN AND BASIC DENTAL PLAN BENEFIT CLAIMS

There are special procedures to follow when you need to file a claim or request review of an adverse determination regarding a claim. The procedures must be followed as outlined below, otherwise your claim or appeal may be denied. If you have any questions regarding the claims and review procedures, call the Trust Fund Office at (562) 463-5065 or (800) 386-4350.

A. Claims Procedures

Discussed below are the various types of claims associated with Major Medical Plan benefits, procedures for filing claims, and the procedure for you to follow if your claim is denied in whole or in part and you wish to appeal the decision.

Section 1. Types of Claims

There are five types of claims applicable to the benefits described in this booklet.

a. **Pre-service claims (applicable only to benefits that require pre-authorization):** A pre-service claim is a request for pre-authorization of a treatment, supply, or service for which the Plan requires a showing that the treatment, supply or service is Medically Necessary before it is obtained.

NOTE: Urgent emergency care does NOT require pre-authorization**.**

b. **Urgent claims:** An urgent claim is a pre-service claim for medical care or treatment that, if normal pre-service standards are applied, would seriously jeopardize the life or health of the claimant or the ability of the claimant to regain maximum function or, in the opinion of a physician with the knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim.

c. **Concurrent care decisions:** A concurrent care claim involves an ongoing course of treatment that is reconsidered after an initial approval was made and that may result in a reduction, termination, or extension of a benefit. An example of this type of claim would be an inpatient hospital stay originally certified for five days that is reviewed after three days to determine if the full five days is appropriate.

d. **Post-service claims:** Any other type of health care claim is considered a post-service claim - for example, a claim submitted for payment after health services and treatment have been obtained.

e. **Disability claims:** A disability claim is any claim that requires a finding of disability as a condition of eligibility. For example, an extension of eligibility requiring a determination of disability.

f. **Other claims:** The category “other claims” includes claims for life insurance and accidental death and dismemberment benefits.

Section 2. Filing a Claim
Unless otherwise indicated, in order to receive benefits, you must file a written claim with the Claims Administrator.

Claims submitted must be accompanied by any information or proof requested and reasonably required to process such claims.

The following changes apply under the federal No Surprises Act of 2022:

1. Prohibition on Balance Billing by Out-of-Network Providers for Services Covered by the No Surprises Act

A Participant or Dependent cannot be billed for charges beyond their Cost-Sharing for Emergency Services rendered by an out-of-network provider in a hospital or Independent Freestanding Emergency Department. The Plan will cover such Emergency Services until the provider or facility determines that the Participant or Dependent is able to travel using nonmedical transportation or nonemergency medical transportation to an in-network facility. In this case, Emergency Services include post stabilization services and services provided as part of outpatient observation or an inpatient or outpatient stay related to an Emergency Medical Condition.

Also, a Participant or Dependent cannot be billed for charges beyond their Cost-Sharing for treatment for non-Emergency Services from an out-of-network provider at an in-network facility unless consent is given as explained below.

Payment for Emergency Services rendered by an out-of-network provider in a hospital or Independent Freestanding Emergency Department, or for non-Emergency Services rendered by an out-of-network provider at an in-network facility will be covered based on the Plan's Allowable Charges.

2. Amount used to Calculate Individual Cost-Sharing for Services Covered by the No Surprises Act

The amount of Cost-Sharing (including deductibles, coinsurance, copays, and the out-of-pocket limit) owed by a Participant or Dependent with respect to Emergency Services rendered by an out-of-network provider or non-Emergency Services rendered by an out-of-network provider in an in-network facility will be determined based on the Recognized Amount. The Recognized Amount is the amount specified by a state all-payer model agreement, or if none, the Recognized Amount is the lesser of the billed amount or the Qualifying Payment Amount (QPA).

There is no out-of-pocket maximum limit on the use of out-of-network providers. However, cost-sharing for such out-of-network services shall count toward amounts owed for deductibles, coinsurance, copays, and out-of-pocket maximums.

3. Notice and Consent Exception to Prohibition on Balance Billing

If the Participant or Dependent gives written, informed consent to treatment by an out-of-network provider at an in-network facility, the Plan will pay benefits at the Out-of-Network Rate.

4. Exceptions to the Availability of Notice and Consent

Written consent cannot be given by the Participant or Dependent if the health care provider is a provider of Ancillary Services (refer to the Definitions section).

5. Payment of Claims under the federal No Surprises Act

Out-of-network providers shall provide medical records to the Plan Administrator or its designee during the claim adjudication process to assist with a determination of whether any charges are subject to the federal No Surprises Act.

Upon confirmation that claims are subject to the federal No Surprises Act, the Plan will make an initial payment or issue a notice of denial of payment within 30 calendar days of receiving a complete or perfected claim from the non-participating provider. The 30-calendar-day period begins on the date the Plan receives the information necessary to decide a claim for payment of the services.

The amount paid to the provider or facility for a claim that is subject to the federal No Surprises Act will be based on the Qualifying Payment Amount (QPA) except where there is a state All-Payer Model Agreement.

If the Plan, provider, or facility requests Independent Dispute Resolution under the No Surprises Act, the Plan will comply with federal regulations.

a. Pre-Service Claims for Medical, Dental and Prescription Benefits (including urgent claims):

1. Your doctor must contact AETNA at 1-888-632-3862 to have certain elective medical procedures or diagnostic tests pre-authorized (see "Major Medical Cost Containment Programs" beginning at page 59). There is a 30% penalty for non-compliance.

2. It is strongly suggested that your dentist call the Trust Fund office at (562) 463-5065 or (800) 386-4350 for pre-certification of prosthesis, periodontal, root canal treatments, orthodontia treatment, and any course of dental treatment which will cost over $500 (see "Dental Limitations and Exclusions" beginning at page 64.)

3. Have your doctor contact Express Scripts at (800) 753-2851 to pre-authorize certain prescription drugs and therapies (see "Prescription Drug Benefit for Major Medical Plan Participants" beginning at page 66).

Pre-service and urgent claims must be filed before services are obtained. If you improperly file a pre-service claim, the appropriate claims administrator will notify you as soon as possible but not later than 5 days after receipt of the claim, of the proper procedures to be followed in filing a claim. You will receive notice of an improperly filed pre-service claim only if the claim includes your name, your specific health condition or symptom and a specific treatment, service or product for which approval is requested. Unless the claim is re-filed properly, it will not constitute a claim.

If you fail to get required prior authorization, your benefits may be denied.

b. Post-Service Claims:

1. Claims for benefits under the **Major Medical Plan** and the **Basic Dental Plan** should be sent to the Trust Fund Office at the following address:

O.P.E.I.U. LOCALS 30 & 537 HEALTH AND WELFARE FUND
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
Phone: (562) 463-5065
(800) 386-4350

Claim forms can be obtained by calling the Trust Fund Office or they can be downloaded from www.opeiufunds.org.

You must submit all post-service claims within 90 days following the date the charges were incurred. Failure to file claims within the time required shall not invalidate or reduce any claim if it was not reasonably possible to file the claim within such time. However, in that case, the claim must be submitted as soon as reasonably possible and in no event later than 1 year from the date the charges were incurred.

2. Kaiser HMO Enrollees

There is no need to file a claim if you are enrolled in the Kaiser Permanente HMO plan and obtain treatment or services from a provider at a Kaiser facility. Please refer to the Kaiser Permanente **Evidence of Coverage** (EOC) which is available online at www.opeiufunds.org for information on claims and appeals procedures.

Contact Kaiser directly to make an appointment or to ask questions about services, claims procedures or providers:

- Kaiser California Toll free 1-800-464-4000 or www.kaiserpermanente.org
- Kaiser ColoradoToll free 1-800-632-9700 or www.kaiserpermanente.org

3. Vision Benefits

There is no need to file a claim if you are enrolled in the Vision Service Plan (VSP) and receive services from a VSP provider. You will receive an explanation of benefits (EOB) report through the mail which provides payment information about the vision services you received.

Contact VSP directly to make an appointment or to ask questions about vision services, claims procedures or providers:

- Vision Service Plan Toll free 1-800-877-7195 or www.vsp.com

4. Dental Benefits

There is no need to file a claim if you are enrolled in the United Concordia dental plan and receive services from a United Concordia dental provider. You will receive an explanation of benefits (EOB) report through the mail, which provides payment information about the services you received from your dentist.

Contact United Concordia directly to make an appointment or to ask questions about dental services, claims procedures or providers:

- United Concordia Toll free 1-866-357-3304 or www.unitedconcordia.com

5. Prescription Drug Benefits

Except for drugs that require prior authorization (see page 67), there is no need to file a claim if you obtain prescription drugs over the counter from a pharmacy that participates in the Express Scripts program. Just present your Express Scripts prescription drug card at the time of sale and pay the copayment. You may also obtain prescription drugs using the Express Scripts' Mail Service prescription program which is set up to dispense up to a 90-day supply of maintenance medications which are generally needed for chronic medical conditions.

Call the Express Scripts Customer Service Department toll free at (800) 451-6245 with questions or to help locate the Express Scripts pharmacy nearest you. You may also visit the Express Scripts website (www.express-scripts.com).

6. Life Insurance or Accidental Death and Dismemberment Benefits

To initiate a claim for life insurance, your designated beneficiary should send a certified copy of your death certificate to the Trust Fund Office. The necessary claim form will then be sent to the beneficiary.

To initiate a claim for accidental death and dismemberment insurance, you should notify the Trust Fund Office of the loss as soon as possible. The necessary claim forms will then be sent to you.

c. Concurrent Claims

All hospital admissions will be reviewed during your stay to determine whether continued hospitalization is medically necessary ("concurrent review"). (See "PRE-ADMISSION AND CONCURRENT REVIEW PROGRAM" beginning at page 59) Concurrent review will be initiated by AETNA contacting your doctor or hospital.

d. Disability Claims

If you are determined to be totally disabled and lose eligibility, you may submit a claim to the Trust Fund Office to extend coverage for the specific disability that exists before termination of eligibility. Total Disability must be confirmed in writing by the attending physician. (See "EXTENSION OF MEDICAL COVERAGE DURING TOTAL DISABILITY" at page 37) Also, if an Employee is on Worker's Compensation or California State Disability, the employer, if specified in its Collective Bargaining Agreement, may make a full monthly contribution at the current contribution rate to maintain coverage for that Employee, for a period up to but not exceeding SIX months. Proof of disability may be required by the Fund Office. (See "EMPLOYER PAID COVERAGE" under the section on "CONTINUATION OF COVERAGE" beginning at page 29)

Section 3. How Claims are Processed

Claim forms received in the Trust Fund Office are first examined to determine whether or not all pertinent information has been included. Claim forms containing all required information are processed by a Trust Fund Claims Examiner. A decision on your claim will be sent to you in writing within 15 days for a pre-service claim and within 30 days for a post-service claim after receipt of your claim. For urgent care claims, the decision will be rendered within 72 hours after receipt of your claim and may be provided to you orally with the written notice sent to you no later than 3 days after the oral notification. A description of the expedited review process will also be provided to you.

If all information necessary for processing has not been included, the Trust Fund Office will request additional information from you as follows:

1. Within 24 hours for any urgent claim for medical care or treatment that may jeopardize your life, health, or ability to regain maximum function, or in the opinion of your physician could subject you to severe pain if care or treatment is not received promptly.

2. Within 5 days for any claim for a benefit that requires you to obtain approval before you receive medical care or treatment (pre-service claims).

3. Within 30 days for any claim for medical care or treatment that you have already received (post-service claims).

If additional information is requested from you, the time period for making a decision on your claim will be suspended for 45 days (48 hours for urgent care claims) from the date you are notified or until a response is received from you, whichever is earlier.

The time period for making a decision may also be extended an additional 15 days for pre-service and post-service claims if there are special circumstances beyond the control of the Trust Fund Office. You will be sent a written notice within the initial 15 days for pre-service claims and within the initial 30 days for post-service claims if an extension is required.

If you fail to cooperate with such requests, your claim may be denied. If your claim is denied, in whole or in part, a notice of denial will be sent to you or your representative.

You may direct benefit payments to be made to the person or facility providing the medical care. Otherwise, payment will be made directly to you if no such direction was made. An "advice of payment" is always sent to you, which shows the charges you submitted, the payments the Fund is able to allow and the balance, if any, which is your responsibility to pay.

Benefits will be paid only if notice of a claim is submitted within 90 days from the date expenses were incurred, unless the Employee can show it was not reasonably possible to give notice within that time limit. **However, in no event shall benefits be allowed if the claim is submitted beyond one year from the date on which expenses were incurred.**

Concurrent Care Claims
If you have any claim that results from the termination or reduction of previously granted benefits to be provided over a period of time, the Plan will notify you in advance of the termination or reduction to allow you time to appeal the decision and obtain a determination before the benefit is reduced or terminated.

Also included under this category are requests to extend the course of treatment beyond the initial prescribed period of time or number of treatments for urgent cases. In these situations, the Plan will inform you of the decision within 24 hours after receipt of the claim by the Plan, provided the claim is made to the Plan at least 24 hours before the expiration of the initially approved treatment. If such a claim were denied, it would be appealable as an urgent care claim.

Any request to extend a course of treatment that does not involve urgent care is a claim that is governed by the standards generally applicable to such claims.

All or Part of a Claim May be Denied
It is not unusual that some charges submitted for a particular claim may be denied. For instance, a person might use a private room which costs more than semi-private. The person might have charges on his hospital bill for TV and telephone calls. Such charges are denied because they are not covered charges. Some claims submitted are not covered at all and in such cases, the reason for denial is sent to the employees involved. Common reasons for denial are:

1. The expenses were incurred during a month that the employee was not eligible.

2. The expenses were incurred as the result of an injury occurring on the job.

These are, of course, not all the possible reasons for denial. They are only examples of denials that occur quite frequently.

B. Appeals Procedures

Section 1. Filing an Appeal

1. No participant, active or retired, dependent or beneficiary of either one or the other person shall have any right or claim to benefits other than as specified in such eligibility resolutions as the Trustees shall determine and establish. If any claimant shall have a dispute as to eligibility, type, amount or duration of such benefits, the dispute shall be resolved by the Board of Trustees, as hereinafter set forth.

2. Any person whose application for benefits has been denied in whole or in part shall be notified of such decision in writing. Such notice shall set forth the specific reason or reasons for the denial, contain specific references to pertinent provisions upon which the denial is based, describe any additional material or information necessary for the claimant to perfect the claim and explain why such material or information is necessary, include a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records and other information relevant to your claim (these relevant documents include any information that was relied upon, submitted, considered or generated in the course of making the benefit decision); if an internal rule, guideline, protocol or other similar criterion was relied upon in making the claim determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request; if a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the claim determination, you will be provided with a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the plan to your medical circumstances, will be provided to you free of charge upon request; and a description of the Plan's claim review procedures including a statement of your right to bring a civil action under section 502 (a) of ERISA if your claim on review is denied.

   In the case of a denial on a claim involving urgent care:
   The information described above and a description of the expedited review process for urgent care claims may be provided to you orally within 72 hours after receipt of your claim by the Plan. The written notice will be furnished to you not later than 3 days after the oral notification.

   Expedited review process for urgent care claims:
   A request for an expedited appeal for an urgent care claim may be submitted orally or in writing by you and all necessary information, including the Plan's benefit determination, will be transmitted to you by telephone, facsimile, or other available expeditious methods.

3. If you desire further consideration of the decision denying the claim, you may request a review upon written application to the Board of Trustees. In connection with such request for review, you or your authorized representative shall be entitled to submit issues and comments in writing to the Board of Trustees, which shall be considered in arriving at a decision on review.

4. Request for review shall state in clear and concise terms the reason or reasons for disagreement with the decision and shall be filed with the Trust Fund Office within 180 days after the date on which you receive the decision denying the claim. Failure to file a request for review within such 180-day period shall constitute a waiver of your right to a review of the decision and your right to file suit in a state or federal court. You must exhaust the Plan's administrative appeals procedures before you can file suit in a state or federal court.

5. Upon receipt of a request for review, the Board of Trustees shall review the administrative file, including the request for review at the Trust Fund Office. The Board of Trustees will review all submitted comments, documents, records, and other information related to the claim, regardless of whether the information was submitted or considered in the initial claim decision. The Board of Trustees will not give deference to the initial claim decision.

6. If the claims denial is based in whole or in part on a medical judgment (including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate), the Board of Trustees will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the judgment. The health care professional will be an individual who is neither the individual consulted in connection with the initial claim decision nor the subordinate of such individual. The Board of Trustees will provide you with the identification of any medical or vocational expert whose advice was obtained in connection with a claim denial, without regard to whether the advice was relied upon in making the denial.

7. The claimant shall be advised of the decision of the Board of Trustees in writing, which shall include the specific reasons for the denial; reference to the pertinent Plan provisions on which the denial is based; a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your claim for benefits; a statement describing any voluntary appeal procedures offered by the Plan and your right to obtain information about such procedures; a statement of your right to bring a civil action under section 502 (a) of ERISA; if an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request; if a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that the explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request; and a statement that you and your Plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency.

8. You will be informed of the decision on your request for review within 72 hours for an urgent care claim and within 30 days for a pre-service claim.

   For post-service claims, the decision will be made by the Board of Trustees no later than the date of the meeting that immediately follows the receipt of the request for review by the Trust Fund Office. If the request for review is received within 30 days before the date of such meeting, the decision will be made no later than the date of the second meeting following the receipt of the request for review. If special circumstances require further extension, the decision will be rendered not later than the third meeting of the Board of Trustees following receipt of the request for review. A written notice will be mailed to you prior to the extension. The Trust Fund Office will notify you of the decision as soon as possible, but not later than 5 days after the decision is made.

9. In performing its review of any claim, the Board of Trustees is expressly authorized to exercise its unrestricted discretion to interpret any provision of Plan documents, its rules or regulations, the Summary Plan Description, the Trust Agreement, and any other documentation relating to the Trust Fund or the claim.

Section 2. External Review of Denied Claims

a. Time Frame and Procedures for Standard External Review

1. External Review Procedures: Your Obligations. You may request an external review, by an Independent Review Organization ("IRO"), only in the situation where your appeal of a health care claim, whether urgent, concurrent, pre-service or post-service claim is denied, and it fits within the following parameters:

   (a) The denial involves medical judgment, including but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, an adverse determination related to coverage of routine costs in a clinical trial, or a determination that a treatment is experimental or investigational. The IRO will determine whether a denial involves a medical judgment;

   (b) The denial is due to a Rescission of coverage (retroactive elimination of coverage), regardless of whether the Rescission has any effect on any particular benefit at that time; and/or

   (c) The denial is related to an Emergency Service, Non-Emergency Service provided by an out-of-network provider at an in-network facility, and/or Air Ambulance service, as covered under the federal No Surprises Act.

2. External review is not available for any other types of denials, including life insurance, disability benefits, dental or vision coverage or if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan.

3. The Plan assumes responsibility for fees associated with External Reviews. Generally, you may only request external review after you have exhausted the internal claims and appeals process described above. This means that, in the normal course, you may only seek external review after a final determination has been made on an appeal. For more information about the External Review procedures, contact the Administrative Office.

4. A request for an external review must be submitted, in writing, by the claimant, his authorized representative or In-Network Provider to the Fund within four months after the date of receipt of a notice of an Adverse Benefit Determination or final internal Adverse Benefit Determination. Within five business days following the date of receipt of the external review request, the Plan will complete a preliminary review of the request to determine whether the request is eligible for external review.

   (a) Within one business day after completion of the preliminary review, the Plan will issue a notification in writing to the claimant.

      (1) If the request is complete and eligible for external review it will be sent to an Independent Review Organization (IRO) for review.

      (2) If the request is complete but not eligible for external review, the notification will include the reasons for its ineligibility and contact information for any applicable office of health insurance consumer assistance.

      (3) If the request is not complete, the notification will describe the information or materials needed to make the request complete. In addition, the Plan will allow a claimant to perfect the request for external review within the four-month filing period or within the 48 hour period following the receipt of the notification, whichever is later.

(b) The assigned IRO will timely notify the claimant in writing of the request's eligibility and acceptance for external review.

(1) The notice will include a statement that the claimant may submit in writing to the assigned IRO additional information that the IRO must consider when conducting the external review; however, the additional information must be received within 10 business days following the date of receipt of the notice.

(c) The IRO will review all of the information and documents timely received. In reaching a decision, the assigned IRO will review the claim de novo and not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, will consider the following in reaching a decision:

(1) The claimant's medical records.

(2) The attending health care professional's recommendation.

(3) Reports from the appropriate health care professionals and other documents submitted by the Plan, claimant, or the claimant's treating Provider.

(4) The terms of the claimant's plan to ensure that the IRO's decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law.

(5) Appropriate practice guidelines, which must include applicable evidence-based standards and may include any other practice guidelines developed by the Federal government, national or professional medical societies, boards, and associations.

(6) Any applicable clinical review criteria developed and used by the Plan, unless the criteria are inconsistent with the terms of the Plan or with applicable law; and

(7) The opinion of the IRO's clinical review or reviewers to the extent the information or documents are available, and the clinical reviewer or reviewers consider appropriate.

(d) The assigned IRO must provide written notice of the final external review decision within 45 days after the IRO receives the request for the external review. The IRO must deliver the notice of final external review decision to the claimant and the Plan.

(e) The assigned IRO's decision notice will contain:

(1) A general description of the reason for the request for external review, including information sufficient to identify the claim (including the date or dates of service, the health care provider, the claim amount (if applicable), the diagnosis code and its corresponding meaning, the treatment code and its corresponding meaning, and the reason for the previous denial).

(2) The date the IRO received the assignment to conduct the external review and the date of the IRO decision.

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

(4) A discussion of the principal reason or reasons for its decision, including the rationale for its decision and any evidence-based standards that were relied on in making its decision.

(5) A statement that the determination is binding except to the extent that other remedies may be available under State or Federal law to either the Plan or the claimant.

(6) A statement that judicial review may be available to the claimant; and

(7) Current contact information, including phone number, for any applicable office of health insurance consumer assistance.

(f) After a final external review decision, an IRO must make records available for examination by the claimant, Plan, or State or Federal oversight agency upon request, except where disclosure would violate State or Federal privacy laws.

(g) Upon receipt of a notice of a final external review decision reversing the adverse benefit determination or final internal adverse benefit determination, the Plan immediately must provide coverage or payment (including immediately authorizing or immediately paying benefits) for the claim.

b. Time Frame and Procedures for Expedited External Review

1. A claimant may request an expedited external review with the Plan at the time the claimant receives:

(1) An Adverse Benefit Determination if the Adverse Benefit Determination involves a medical condition of the claimant for which the timeframe for completion of an expedited internal appeal would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function and the claimant has requested a request for an expedited internal appeal; or

(2) A final internal Adverse Benefit Determination, if the claimant has a medical condition where the timeframe for completion of a standard external review would seriously jeopardize the life or health of the claimant or would jeopardize the claimant's ability to regain maximum function, or if the final internal Adverse Benefit Determination concerns an admission, availability of care, continued stay, or health care item or service for which the claimant received Emergency services, but has not been discharged from a facility.

2. Immediately upon receipt of the request for expedited external review, the Plan must determine whether the request meets the reviewability requirements for standard external review. The Plan must immediately send a notice to the claimant of its eligibility determination.

3. Upon a determination that a request is eligible for external review following the preliminary review, the Plan will assign an IRO. The Plan must provide all necessary documents to the assigned IRO as expeditiously as possible.

4. The assigned IRO, to the extent the information or documents are available, and the IRO considers them appropriate, must consider the information or documents submitted. In reaching a decision, the assigned IRO must review the claim de novo and is not bound by any decisions or conclusions reached during the Plan's internal claims and appeals process.

5. The assigned IRO must provide notice of the final external review decision as expeditiously as the claimant's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives the request for an expedited external review. If the notice is not in writing, within 48 hours after the date of providing that notice, the assigned IRO must provide written confirmation of the decision to the claimant and the Plan.

Section 3. Prescription Drug Appeals and Reviews

An appeal subsequent to a (non-eligibility related) prescription drug claim denial will be directed to an independent reviewer at Express Scripts. Please notify the Trust Fund Office to assist you with a prescription drug appeal.

Section 4. Exhaustion of Administrative Remedies and One Year Time Limitation for Bringing a Lawsuit for Plan Benefits Under ERISA

You may not file a lawsuit to claim Plan benefits under ERISA Section 502(a) until you have exhausted all of the Plan's administrative remedies, including the Plan's Claims and Appeals Procedures described above.

In the event your claim is denied in the course of your exhaustion of the Plan's administrative remedies set forth in the Plan's Claims and Appeals procedures described above, you must commence any lawsuit under Section 502(a) of ERISA respecting such claim not later than the first anniversary of the date of the written notice of decision on the appeal denying such claim.

DEFINITIONS

1. **Air Ambulance Service:** Medical transport by helicopter or airplane for patients.

2. **Allowable Charges:** The customary charge, in the area in which it is incurred, but not exceeding such charge as would have been made in the absence of benefits provided under this Plan. A "customary charge" as used herein, means the usual charge made by a Hospital, Doctor, or other professional person, or other person or firm having rendered or furnished services, treatments or supplies which do not exceed the general level of charges made by others rendering or furnishing such services, treatments or supplies within the area in which the charge is incurred, for bodily injuries or sicknesses comparable in severity and nature to the bodily injuries or sicknesses treated or being treated. Allowable Charge will not exceed the actual charge and means the usual, customary, and reasonable amount determined by the Board of Trustees to be payable for a Covered Expense.

   The term "area," as it would apply to any particular item for which an Allowable Charge may be incurred, means a county or such greater area as is necessary to obtain a representative cross-section of entities furnishing such items.

   A charge is considered to have been incurred as of the date on which the service or supply for which the charge is made is rendered or obtained.

3. **Ancillary Services:**

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

   (b) Items and services provided by assistant surgeons, hospitalists, and intensivists.

   (c) Diagnostic services, including radiology and laboratory services; and

   (d) Items and services are provided by an out-of-network provider if there is no in-network provider who can furnish such items or service at such a facility.

4. **Collective Bargaining Agreement** includes:

   (a) any collective bargaining agreements between the Unions and any employer which provides for the making of employer contributions to this Fund.

   (b) Any extensions, amendments, modifications or renewal of any of the above-described agreements, or any substitute or successor agreements to them which provide for the making of employer contributions to this Fund.

5. **Continuing Care Patient:** An individual who, with respect to a provider or facility:

   (a) Is undergoing a course of treatment for a Serious and Complex Condition from the provider or facility;

   (b) Is undergoing a course of institutional or inpatient care from the provider or facility;

   (c) Is scheduled to undergo non-elective surgery from the provider, including receipt of postoperative care from such provider or facility with respect to such surgery;

(d) Is pregnant and undergoing a course of treatment for the pregnancy from the provider or facility; or

(e) Is determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and is receiving treatment for such illness from such provider or facility.

6. **Contributing Employer:** Any employer, including individual, partnership, corporation, firm, or other entity, which has entered into a Collective Bargaining Agreement with the Union, providing for contributions into the Fund, or such other employer as the Trustees may approve from time to time, if allowed by the Agreement of Trust establishing this Fund.

7. **Contribution:** The payment made or to be made to the Fund by any Contributing Employer under the provisions of a Collective Bargaining Agreement or subscriber agreement.

8. **Contribution For Dependent Coverage:** Your employer's Collective Bargaining Agreement and any policy established by the Board of Trustees may require that you or your employer make contributions if you elect dependent coverage.

9. **Cost-sharing:** The amount a Participant, Dependent, or enrollee is responsible for paying for a covered item or service under the terms of the group health plan or health insurance coverage. Cost-sharing generally includes copayments, coinsurance, and amounts paid towards deductibles but does not include amounts paid towards premiums, balance billing by out-of-network providers, or the cost of items or services that are not covered under a group health plan or health insurance coverage.

10. **Covered Expense:** Those charges which are eligible for benefit payment according to the Major Medical Plan, which are determined by the Major Medical Plan to be medically necessary for the treatment of an injury or sickness and are not expressly excluded by the Major Medical Plan.

11. **Custodial Care:** Custodial care, or domiciliary care or care in an institution, primarily a place of rest for the aged, nursing home or any like institution. As further consideration for the Board of Trustees, the term, "Custodial Care" shall have the same meaning as contained in the federal Dependents' Medical Care Act, commonly known as "CHAMPUS," and regulations implementing the Act and the definition of custodial care contained therein.

12. **Deductible:** The amount you pay before the Plan pays benefits. Charges not considered Covered Expense may not be used to satisfy the deductible.

13. **Dependent:** The Employee's lawful spouse and (a) unmarried natural children less than 26 years of age; (b) unmarried stepchild, child under legal guardianship (proof of legal guardianship is required), legally adopted child, foster child, or child placed for adoption, less than 26 years of age. When enrolling a Dependent, a copy of the marriage certificate, birth certificate, or Court Order will be requested.

    Dependent shall include an unmarried child of the Employee who, upon attainment of the age limit specified above, is incapable of self-sustaining employment by reason of mental or physical handicap (provided the condition of the child existed before attainment of the age limit and while eligible hereunder) and who is solely dependent upon the Employee for support. The Board of Trustees may subsequently require proof of continuing incapacity. This extension of coverage under the Plan will continue until the earliest of: (1) the date he or she ceases to be eligible for reasons other than age, (2) the date he or she ceases to be incapacitated, or (3) the 31st day after the Trustees request, in writing, additional proof of incapacity and such proof is not furnished within the period of time, or any extension thereof granted by the Trustees.

    A Dependent shall also include an Employee's child who is the subject of a Qualified Medical Child Support Order.

No other dependents will be covered under the Plan even though you may be morally or financially responsible for them.

A spouse or child in the full-time military, naval or air service will not be considered an eligible dependent.

THE TERM DEPENDENT WILL NOT INCLUDE ANY PERSON WHO IS THE SPOUSE OF AN ELIGIBLE EMPLOYEE AND WHO (1) HAS COVERAGE AS A RETIREE UNDER AN EMPLOYER SPONSORED PLAN OF GROUP COVERAGE AND (2) IS ELIGIBLE FOR FEDERAL MEDICARE COVERAGE.

14. **Doctor (Physician):** A Doctor of Medicine or Doctor of Osteopathy. To the extent that benefits are provided and while practicing within the scope of his/her license, doctor will also include physician assistant, assistant surgeon, anesthesiologist, dentist, podiatrist, chiropractor, acupuncturist, optometrist, ophthalmologist, or psychologist. Doctor will not include you or your dependents or any person who is the spouse, parent, child, brother, or sister of you or your dependent.

15. **Drugs:** Any article which can be lawfully dispensed, as provided under the Federal Food, Drug and Cosmetic Act including any amendments thereto, only upon a written or oral prescription of a Doctor or Dentist licensed by law to administer it.

16. **Emergency:** A sudden onset of a medical condition which in the absence of immediate medical attention could reasonably place the Participant's health in jeopardy, cause serious medical consequences, cause serious impairment to bodily functions, or cause serious and permanent dysfunctions of any bodily organ or part.

17. **Emergency Medical Condition:** A medical condition, including a mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in a condition described in clause (i), (ii), or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. Section 1395dd(e)(1)(A)). (In that provision of the Social Security Act, clause (i) refers to placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; clause (ii) refers to serious impairment to bodily functions; and clause (iii) refers to serious dysfunction of any bodily organ or part.)

18. **Emergency Services:**

    (a) An appropriate medical screening examination that is within the capability of the emergency department of a hospital or an independent freestanding emergency department, as applicable, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and

    (b) Within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, as applicable, such further medical examination and treatment are required to stabilize the patient (regardless of the department of the hospital in which such further examination or treatment is furnished).

19. **Employee:** An individual within a unit covered by a Collective Bargaining Agreement providing for contributions to the Office and Professional Employees Locals 30 & 537 Health and Welfare Fund.

20. **Expenses Incurred:** Only the usual, customary, and reasonable fees and prices regularly and customarily charged for the medical services and supplies generally furnished for cases of comparable nature and severity in the particular geographical area concerned. Any agreement as to fees or charges made between you and a Doctor or Hospital will not bind the Trust in determining its liability with respect to expenses incurred. Expense incurred is determined to be incurred on the date on which the service or supply which gives rise to the expense or charge is rendered or obtained.

21. **Extended Care Facility:** An institution which is primarily engaged in providing in-patients with (1) skilled nursing care and related services for patients who require medical or nursing care, or (2) rehabilitative services for the rehabilitation of injured, disabled, or sick persons, and which meets all of the following requirements:

    (a) it is regularly engaged in providing skilled nursing care for sick and injured persons under 24 hours a day supervision of a Doctor or a Registered Nurse;

    (b) it has available at all times the services of a Doctor who is a staff member of a Hospital;

    (c) it has on duty 24 hours a day a Registered Nurse, licensed vocational nurse (L.V.N.), or skilled practical nurse, and it has a Registered Nurse on duty at least eight hours per day.

    (d) it maintains a clinical record for each patient.

    (e) it is not, other than incidentally, a place for rest, a place for drug addicts, a place for alcoholics, a hotel or a similar institution.

    (f) it complies with all licensing and other legal requirements and is recognized as an "Extended Care Facility" by the Secretary of Health and Human Services of the United States pursuant to Title XVII of the Social Security Amendments Act of 1965, as amended.

22. **Fund:** The Office and Professional Employees Locals 30 & 537 Health and Welfare Fund.

23. **Home Health Care Agency:** An organization or agency which meets the requirements for participation as a "home health care agency" under Medicare.

24. **Hospice:** A hospice or public agency or private organization that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

25. **Hospital:** A "legally constituted hospital" means an institution which meets all of the following requirements:

    (a) It is engaged primarily in providing medical care and treatment of sick and injured persons on an in-patient basis at the patient's expense and maintains diagnostic and therapeutic facilities for surgical and medical diagnosis and treatment of such persons by or under the supervision of a staff or duly qualified physicians.

    (b) It continuously provides 24 hours a day nursing service by or under the supervision of registered graduate nurses and is operated continuously with organized facilities for operative surgery.

    (c) It is not, other than incidentally, a place of rest, a place for the aged, a place for the treatment of drug addiction or alcoholism, a place for the mentally ill or emotionally disturbed, or a nursing home; and

    (d) A psychiatric hospital as defined by Medicare which is qualified to participate in and is eligible to receive payment under and in accordance with the provisions of Medicare relative to psychiatric inpatient care.

26. **Independent Freestanding Emergency Department:** A healthcare facility that is geographically separate and distinct and licensed separately from a hospital under applicable State law and provides any Emergency Services.

27. **Major Medical Plan:** As described herein whereby you are free to choose your own physician and your own hospital, to avail yourself of any service provided under the program. Allowance for hospital expenses, as well as surgical procedures, are limited as indicated herein.

28. **Medically Necessary:** At the sole and absolute discretion of the Board of Trustees, each service or supply meets all of the tests listed below:

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

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

    (c) it is not mainly for the convenience of the Participant or of the Participant's Doctor or other provider; and

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

29. **Medicare:** The program established under Title XVII of the Social Security Act (Federal Health Insurance for the Aged) as it is presently constituted or may thereafter be amended.

30. **Open Enrollment:** The month of January of each year. This is the period of time in which you may elect to change from either the Major Medical Plan or Kaiser Foundation Health Plan and the Basic Dental Plan or the United Concordia Pre-Paid Dental Plan. **If you have not previously covered your dependents, you may do so during the open enrollment period.** Enrollment Cards must be received by the Trust Fund Office no later than January 31st of each year in order for your coverage to be changed effective February 1st. See pages 45 and 46.

31. **Out-of-Network Rate:** One of the following amounts, less any cost-sharing from the participant, beneficiary, or enrollee: (1) An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act; (2) if there is no such applicable All-Payer Model Agreement, an amount determined by specified state law; (3) in the absence of an applicable All-Payer Model Agreement or specified state law, if the plan or issuer and the provider or facility have agreed on a payment amount, the agreed-on amount; or (4) if none of those three conditions apply, and the parties enter into the IDR process and do not agree on a payment amount before the date when the IDR entity makes a determination of the amount, the amount determined by the IDR entity.

32. **Participant:** An eligible Employee or eligible Dependent.

33. **Pre-Paid Plan:** Any plan entered into by contract between the Fund and any outside organization to provide pre-paid benefits to the participants of this Trust Fund in lieu of those benefits provided under the Major Medical Plan, or Basic Dental Plan.

34. **Qualifying Payment Amount:** The amount that is calculated using the methodology described in 29 Code of Federal Regulations § 716-6(c) as determined by the Network claims administrator.

35. **Recognized Amount:**

(a) An amount determined by an All-Payer Model Agreement under section 1115A of the Social Security Act;

(b) If no All-Payer Model Agreement exists, an amount determined by specified state law; or

(c) If no All-Payer Model Agreement or specified state law exists, the lesser of:

1. the amount billed by the provider/facility or

2. the Qualifying Payment Amount (QPA) for the item or service.

36. **Serious and Complex Condition:** With respect to a participant or beneficiary under a group health plan or group health insurance coverage:

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

(b) in the case of a chronic illness or condition, a condition that-

1. is life-threatening, degenerative, potentially disabling, or congenital; and

2. requires specialized medical care over a prolonged period of time.

37. **Registered Nurse:** A registered graduate nurse.

38. **Totally Disabled:** If your eligibility is based on active employment, you will be considered totally disabled while, as a result of bodily injury or sickness, you are prevented continuously from engaging in any occupation for which you are qualified by reasons of education, training or experience.

A person whose eligibility is not based on active employment will be considered totally disabled while, as a result of bodily injury or sickness, he or she is unable to engage in his or her regular and customary activities and is not engaged in any occupation for wages or profit.

39. **Union:** Office and Professional Employees International Union Local 30 and Office and Professional Employees International Union Local 537.

ELIGIBILITY RULES

The following only applies if eligibility provisions are not addressed in a collective bargaining agreement approved by the Board of Trustees:

EMPLOYEE

Who is Eligible?
Any full-time, regular part-time or temporary employee for whom a full monthly contribution (as determined by the Board of Trustees) has been paid by one or more participating employers.

When an Employee Becomes Eligible
Hours worked in one month (February, for example) are paid by contributions in the following month (March) and provide eligibility for the following month (April). Full monthly contributions as determined by the Trustees must be made to initiate and maintain eligibility for medical and dental benefit coverage.

Hours Worked by Participant	Contribution Paid by Employer	Eligibility Granted by Trust
January	February	March
February	March	April
March	April	May
April	May	June
May	June	July
June	July	August
July	August	September
August	September	October
September	October	November
October	November	December
November	December	January
December	January	February

Reinstatement
If an employee is terminated and returns to active employment, he/she will become eligible as provided for above.

Effective Date of Coverage
Employees will become covered on the date they become eligible.

Termination of Coverage
Coverage for a participant will automatically terminate on the earliest of the following dates:

1. On the date the expiration of the period for which the last required contribution was made.

2. Subject to the section on Continuation of Coverage During Military Service, upon the date of entry into full-time military service.

3. On the day, the employee becomes covered under another health and welfare program.

4. The date the Board of Trustees terminates the benefits provided by the Fund.

DEPENDENT

Medical and Dental coverage for eligible dependents* is optional and is available at a monthly cost to you. If you wish to enroll your dependents, be sure to list them on the enrollment card(s) and notify your Employer immediately to ensure that the appropriate payroll deductions are made and remitted accordingly to avoid any additional retro-payments on your part.

* *See definition of Dependent on page 21.*

Who is Eligible?
If an employee wishes to enroll dependents as defined herein, they must be enrolled at the same time as the Employee. Thereafter, any person who becomes a dependent, such as a new spouse or newborn child, may be enrolled by the employee submitting an updated enrollment form within 30 days from the date of marriage or birth.

Dependents not previously enrolled may ONLY be enrolled as dependents during the OPEN ENROLLMENT PERIOD by submitting an enrollment application. See pages 45 and 46 for additional details regarding general enrollment information, Open Enrollment and Special Enrollment Rights.

Effective Date of Coverage
Dependents will become covered (subject to "Enrollment" above) as follows:

1. If written application is made within 30 days after the Employee becomes eligible, dependent coverage shall take effect on the first day of the month following the month for which a dependent contribution is received.

2. Coverage for a newly eligible dependent shall become effective on the first day of the month following receipt of the enrollment card (received within 30 days from the date that the dependent was acquired) and providing any necessary payment for dependent coverage has also been made.

3. The date following release from active duty in the military (provided the required dependent contribution is made).

Termination of Coverage
The coverage of the dependent shall terminate on the earliest of: (1) the date the dependent ceases to be a dependent as defined herein; (2) the date the Employee's eligibility terminates; (3) the date the dependent premium is due and not paid to the Trust Fund; or (4) subject to the section on Continuation of Coverage During Military Service, the date the dependent enters into full-time active duty with the Armed Services.

Qualified Medical Child Support Orders (QMCSO)
Federal law requires the Plan, under certain circumstances, to provide coverage for your children when you and your spouse divorce. The process begins when the plan receives a Qualified Medical Child Support Order (QMCSO). This means any judgment, decree, or order, including approval of a settlement agreement, which:

1. Issues from a court of competent jurisdiction pursuant to a state’s domestic relations law;

2. Requires you to provide only the group health coverage available under the plan for your children, even though you no longer have custody; and

3. Clearly specifies:

   (a) Your name and last known mailing address and the names and addresses of each child covered by the order;

   (b) A reasonable description of the coverage to be provided;

(c) The length of time the order applies; and

(d) Each plan affected by the order.

If the Plan receives an order and it is determined to be qualified, the child will be enrolled on the date of the determination or the date the necessary payment for dependent coverage is received, whichever is later. You must be a participant under the Plan before any dependent may be covered by the Plan. The child's custodial parent, legal guardian, or a state agency can make application for coverage, even if you do not. If you have any questions on any of these requirements, please contact the Trust Fund Office.

Premium Assistance Under Medicaid and the Children's Health Insurance Program (CHIP)
If you or your children are eligible for Medicaid or CHIP and you're eligible for health coverage from your employer, your state may have a premium assistance program that can help pay for coverage, using funds from their Medicaid or CHIP programs. If you or your children aren't eligible for Medicaid or CHIP, you won't be eligible for these premium assistance programs, but you may be able to buy individual insurance coverage through the Health Insurance Marketplace. For more information, visit www.healthcare.gov.

If you or your dependents are already enrolled in Medicaid or CHIP, contact your State Medicaid or CHIP office to find out if premium assistance is available.

If you or your dependents are NOT currently enrolled in Medicaid or CHIP, and you think you or any of your dependents might be eligible for either of these programs, contact your State Medicaid or CHIP office or dial 1-877-KIDS NOW or www.insurekidsnow.gov to find out how to apply. If you qualify, ask your state if it has a program that might help you pay the premiums for an employer-sponsored plan.

If you or your dependents are eligible for premium assistance under Medicaid or CHIP, as well as eligible under your employer plan, your employer must allow you to enroll in your employer plan if you aren't already enrolled. This is called a "special enrollment" opportunity, and you must request coverage within 60 days of being determined eligible for premium assistance. If you have questions about enrolling in your employer plan, contact the Department of Labor at www.askebsa.dol.gov or call 1-866-444-EBSA (3272).

CONTINUATION OF COVERAGE

EMPLOYER PAID COVERAGE

Disability
If an Employee is on Worker's Compensation or California State Disability, the employer, if specified in its Collective Bargaining Agreement, may make a full monthly contribution at the current contribution rate to maintain coverage for that Employee, for a period up to but not exceeding SIX months. Proof of disability may be required by the Fund Office.

RETIREE PAID COVERAGE

Self-Pay Retirees
If you are an active Employee covered under the Fund, you will be eligible for Self-Pay Retiree coverage if you:

1. Have been under continuous covered employment for a ten-year period immediately preceding retirement, and

2. Retire between the ages of 55 and 64 inclusive, and

3. Continue to pay timely, your contribution rate until you reach age 65 or become eligible for MEDICARE, at which time eligibility under this Plan will cease. The contribution rate for Self-Pay Retirees is the same as COBRA rates.

CONTINUATION OF COVERAGE DURING MILITARY SERVICE

Military Service (USERRA)
The Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) provides protections to individuals who are eligible individuals of the Uniformed Services. Uniformed Services is defined as the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, and the commissioned corps of the Public Health Services.

Military Leaves of Absence for a Period of 30 Days or Less
USERRA provides that if an employee is on a military leave of absence from his employment, and the period of military leave is less than 31 days, he will continue to be eligible for health care coverage under this Plan during the leave with no self-payment required, provided he is eligible for benefits under this Plan at the time his military leave begins.

Military Leaves of Absence for Periods More Than 30 Days
If an employee is on a military leave of absence from his employment, or if the employee's covered Dependent enters the military (thereby otherwise losing coverage under this Plan), and the period of military leave is for more than 30 days, USERRA permits the employee or the employee's Dependent who entered the military to continue coverage for himself and (in the case of the employee) his Dependents at his own expense. The cost is 102% of the Plan's cost of benefits, for up to 24 months, so long as he gives the Administrative Office advance notice (with certain exceptions) of the leave, and so long as his total leave when added to any prior periods of leave, does not exceed 5 years.

The maximum period of continuation coverage for health care under USERRA is the lesser of: (1) 24 months (beginning from the date the employee leaves work due to military leave or the Dependent loses coverage due to military service); (2) the day after the date the employee fails to timely apply for or return to a position of employment with an Employer participating in the Plan; or (3) when the employee or Dependent fails to timely pay for health care under USERRA.

Upon release from active service, the Eligible Employee's coverage will be reinstated on the day he returns to work as if he had not taken leave or as of the date of registration for employment through the Union, provided he is eligible for re-employment under the terms of USERRA and provided he returns to work: (a) within 90 days from the date of discharge if the period of service was 31 days or more; or (b) by the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours) if the period of service was less than 31 days.

If the Eligible Employee is hospitalized or convalescing from an injury caused by active duty, these time limits are extended for up to two years.

A copy of the Eligible Employee's separation papers must be submitted to the Administrative Office to establish his period of service.

If the Eligible Employee does not elect to continue coverage during his military leave, upon his return to work his benefit coverage will be reinstated at the same benefit level afforded to active, Eligible Employees if he/she is eligible for re-employment under the criteria established under USERRA.

If the Eligible Employee does not return to work at the end of his military leave, he may be entitled to purchase COBRA continuation coverage (see page 31) provided he gives timely notice to the Administrative Office. Coverage will not be offered for any illness or injury determined by the Secretary of Veterans Affairs to have been incurred in, or aggravated during, performance of service in the uniformed services. The uniformed services and the Department of Veterans Affairs will provide care for service-connected injuries or illnesses.

The rights to self-pay are governed by the same conditions described in the COBRA section of this SPD. If election is made for continuation coverage under USERRA, the COBRA and USERRA coverage periods will run concurrently.

"COBRA" SELF-PAYMENT

COBRA CONTINUATION COVERAGE
In accordance with the Consolidated Omnibus Budget Reconciliation Act (COBRA), if you and/or your dependents lose coverage under the Plan, you and/or your covered dependents might be eligible to continue your medical, prescription drug, dental and vision coverage by self-payment for a temporary period. You will be allowed to continue only the coverage that you had as an active employee. To be eligible, a qualifying event causing the loss of coverage must take place.

Qualifying Events for Employees and Dependents
A qualifying event occurs:

1. if your employment ends (for reasons other than your gross misconduct); or

2. if your hours are reduced to the point where you would not ordinarily be covered by the Plan.

In this case, you and/or your dependents may continue the coverage you had for up to 18 months following the month in which your termination or reduction in hours occurs. COBRA Continuation Coverage requires payment of 102% of the cost to the plan for similarly situated individuals who have not incurred a qualifying event. COBRA premiums are routinely adjusted effective each February 1.

If, at any time during the first 60 days of COBRA coverage, you or a covered dependent are determined to be disabled pursuant to Title II or Title XVI of the United States Social Security Act, coverage may be continued for an additional 11 months, for a total of 29 months. Coverage may be continued for all family members. The Trust Fund Office must be informed within 60 days of the Social Security determination of disability and before the end of the 18-month continuation coverage period. The cost for the additional 11 months is 150% of the plan's total cost of coverage. In the event you are no longer considered disabled by Social Security, you must notify the Trust Fund Office within 30 days of the date of the Social Security Administration's determination. Your coverage will stop the first day of the month that begins more than 30 days after the re-determination.

Qualifying Events for Dependents
If one of the following qualifying events occurs, your spouse's and/or your children's coverage may be continued for up to 36 months:

1. You die while you and your dependents are covered by the plan.

2. Your divorce or legal separation.

3. You become entitled to Medicare.

4. Your child ceases to be a dependent as defined by the Plan.

If while on continuation coverage due to your termination or reduction in hours, your spouse and/or dependents have another qualifying event; for example, assume that you, your spouse and children continued coverage for 18 months because of your termination of employment; if you died during this 18-month period, your spouse and children may continue coverage for a total of 36 months from the date of termination of employment.

Also, a qualifying event is a proceeding in bankruptcy under Title 11 of the United States Code with respect to an employer from whose employment a covered employee retired at any time.

Type of Coverage
An Eligible Individual may continue his/her "core coverage" only, or both "core plus non-core coverage."

The term "core coverage" as used herein means all Plan benefits provided to similarly situated Eligible Individuals for whom a Qualifying Event has not occurred, except life insurance, accidental death and dismemberment benefits, dental benefits and, for those not enrolled in Kaiser, vision care benefits.

The term "core plus non-core coverage" as used herein means, for those not enrolled in Kaiser, the Plan's "core coverage," dental benefits and vision care benefits provided to similarly situated Eligible Individuals for whom a Qualifying Event has not occurred. For those enrolled in Kaiser, the term "core plus non-core coverage" means the Plan's "core coverage" and dental benefits provided to similarly situated Eligible Individuals for whom a Qualifying Event has not occurred.

If "core plus non-core coverage" is not elected at the time an election is made for initial continuation coverage, it cannot be elected at a later date. You may, however, change your medical from Kaiser to Major Medical Plan or vice versa and from the prepaid dental plan to the Basic Dental Plan or vice versa at Open Enrollment.

Nothing in this section shall be interpreted to give an Eligible Individual the right, at the time continuation coverage is elected, to change his/her coverage option (i.e., Major Medical Plan, Kaiser) from those in effect for him/her on the day preceding the day coverage would otherwise terminate as a result of the qualifying event.

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

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

Withdrawal of Contributing Employer
COBRA continuation coverage will not be offered to you or your dependents if you lose eligibility because your employer withdraws from or is no longer contributing to the Plan.

However, if you or your dependents are covered under COBRA continuation coverage when your former employer stops contributing to this Fund, you may continue your coverage under COBRA until the end of your continuation period (i.e., 18 months, 36 months). But if your former employer has an existing plan or establishes a new plan to cover a class of active employees formerly covered under this Fund, your COBRA continuation coverage will be terminated under this Plan since your former employer is required to provide COBRA continuation coverage for you and/or your dependents.

COVID-19 Extension of Deadlines
Due to the COVID-19 Pandemic, certain employee benefit plan deadlines that occur during the National Emergency that began on March 1, 2020 and will end 60 days after the announced end of the National Emergency (the ·'Outbreak Period") are extended as required by federal law. The Plan must disregard the Outbreak Period when determining deadlines for filing claims and appeals, special enrollment of new dependents or for electing COBRA coverage and payment of COBRA premiums.

By federal law, the period that is disregarded cannot exceed one year and will terminate as of the *earlier* of (a) 1 year from the date that an individual or plan is first eligible for relief, or (b) the end of the Outbreak Period (60 days after the announced end of the National Emergency). This period is referred to as the "Suspension Period." After the Suspension Period ends, the clock begins on any timeframe that started during the Suspension Period. If the timeframe began prior to the start of the National Emergency, the clock resumes running after the Suspension Period ends, and participants and beneficiaries will be permitted to use the remaining number of days they had prior to March 1, 2020.

The deadlines for electing COBRA coverage, paying COBRA premiums, and for notifying the Plan of a Qualifying Event that is a divorce, separation, loss of dependent status, or a disability have been suspended during the Suspension Period and will restart on the earlier of one year following the date you receive notice of a claim denial or 60 days following the announced end of the National Emergency.

Notice Requirement

If your spouse or child qualifies for continuation of coverage due to a qualifying event such as divorce, legal separation, or ceasing to meet the definition of a dependent under the plan, you must notify the Trust Fund Office. This notice should be given before the qualifying event, or as soon as possible thereafter, but not more than 60 days after the qualifying event.

If this notice is not provided to the Trust Fund Office within 60 days, your dependent's right to continue under COBRA will be lost.

In the case of any other Qualifying Event, the Employer will notify the Trust Fund Office.

Once the Trust Fund Office is notified of a Qualifying Event, an election notice will be sent to the Employee and Qualified Beneficiaries explaining their options to continue coverage. This will be addressed to the Employee and dependents at the address of record maintained by the Trust Fund Office. It is the responsibility of all Qualified Beneficiaries to keep the Trust Fund Office informed of their current mailing address.

If you are a covered former employee, you may add your newborn or adopted children to your continuation coverage, provided you add the child(ren) within 30 days of the birth or adoption and pay the additional premium, if any. These children whom you add to coverage will be considered Qualified Beneficiaries under the law.

Election Requirement

You and/or your dependents must make written election on the forms provided within 60 days after the later of:

1. The date coverage would end if no continuation were elected; or

2. The date the COBRA election notice is provided.

The election form must be received by the Trust Fund Office within the stated 60-day period; otherwise, the continuation option expires. Any Qualified Beneficiary who fails to send the election form to the Trust Fund Office to continue coverage within the 60-day period **will not** be permitted to continue any level of coverage.

Waiver of COBRA

If you waive your right to continue coverage under COBRA by writing to the Trust Fund Office and if within the 60-day election period you decide that you would like to continue coverage, you may revoke that written waiver as long as you send in the election form within that 60-day period; however, your coverage will only be reinstated as of the date of your election. You will not have coverage for any claims that you may have incurred between the date of your loss of coverage due to a Qualifying Event and the date that you elected COBRA.

You have the right to request special enrollment in another group health plan which might be available to you (such as through your spouse's employer) within thirty (30) days after termination of your group health coverage if the loss of coverage is due to one or more of the Qualifying Events listed above. You will also have this same special enrollment right if you elect COBRA and continue coverage to the end of the period allowed.

Premium Payment
Your initial premium payment must be paid to the Trust Fund Office within 45 days of the date you elected COBRA. Your payment must cover the period of coverage from the date you elected COBRA to the date of the loss of coverage due to the qualifying event. To ensure continuous coverage, you should enclose your first payment with your election.

Subsequent payments must be received at the Trust Fund Office by the first day of the month preceding each coverage month. The following is a monthly remittance schedule for COBRA contributions:

Coverage Month	Payment Due
February	January 10th
March	February 10th
April	March 10th
May	April 10th
June	May 10th
July	June 10th
August	July 10th
September	August 10th
October	September 10th
November	October 10th
December	November 10th
January	December 10th

If you fail to respond or make the required self-payments according to the schedule outlined above, your coverage will terminate after a grace period of 30 days without further notice, and you will not be permitted to make retroactive payment or payment of any month following the termination of your eligibility. You are responsible for making your monthly COBRA payments by the due date. No bills or reminders will be sent.

To ensure that you receive proper credit for any self-payment made, please include your Social Security Number on your check or cover note and indicate the coverage month for which you are making payment.

Automatic Coverage for Dependents of Covered Employees Choosing Continuation Coverage
When the covered Employee chooses to continue coverage, coverage for his or her spouse and dependents will continue automatically unless the spouse *independently* declines coverage. But, if the covered Employee chooses not to continue coverage, his/her spouse and eligible dependents may still choose coverage. Of course, in all circumstances anyone electing continued coverage must pay for it.

Transfer Rights
If you are covered by a regional plan (like an HMO that covers a limited geographic area), and you relocate to another area where your employer has an active workforce, you are entitled to elect the coverage available to an active employee working in that area. Of course, under no circumstances would such a transfer prolong your 18, 29 or 36 months of COBRA coverage.

Termination of Continued Coverage
The continued coverage will end **automatically** as of the date any of the following situations occur:

1. The date the Plan ends.

2. The date your employer, through which COBRA was elected, is no longer a Contributing Employer and has an existing plan or established a new plan to cover a class of active employees formerly covered under this Plan.

3. The required premiums are not paid on a timely basis. To be paid on a timely basis, the premium must be paid within 30 days of its due date (or within 45 days of the due date for the initial premium payment).

4. The date you become, after the date of election, entitled to Medicare or covered under any other group health plan, which does not contain any exclusion or limitation with respect to any preexisting condition.

5. The first day of the month that begins more than 30 days after the date of the final determination under Title II or XVI of the Social Security Act that the qualified beneficiary is no longer disabled.

6. The date the maximum period of continued coverage has been provided, i.e., 18 or 36 months, or in the case of a disability extension, 29 months.

QUESTIONS
If you have questions about your COBRA Continuation Coverage, you should contact the Trust Fund Office at:

O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
Phone: (562) 463-5065 or (800) 386-4350

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

California COBRA Extension - Medical Benefits (for Kaiser Participants Only)
If you are a COBRA qualified beneficiary with Kaiser on or after January 1, 2003, California law requires HMOs and insurance carriers such as Kaiser to extend your medical continuation coverage up to 36 months (combined federal and state COBRA extensions). California COBRA Extension does not apply to vision or dental coverage. The California COBRA extension will only apply to you if you have an 18-month or 29-month COBRA qualifying event.

In order to be eligible for the California COBRA extension, you must have exhausted your federal COBRA coverage and you must be enrolled in Kaiser on the date your federal COBRA coverage ends.

Your premium may increase to 110% of the cost of coverage and must be paid directly to Kaiser. You must apply for this COBRA extension before the end of your federal COBRA Continuation Coverage. Call the Trust Fund Office or Kaiser for more information.

WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act of 1998 (WHCRA) This coverage is subject to the applicable co-payments, annual deductible and co-insurance provisions of the plan in which you are enrolled.

For individuals receiving mastectomy related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

- all stages of reconstruction of the breast on which the mastectomy was performed;
- surgery and reconstruction of the other breast to produce a symmetrical appearance;
- prostheses; and
- treatment of physical complications of the mastectomy, including lymphedema.

WHCRA prohibits circumventing the law by denying eligibility, penalizing providers, and providing incentives (monetary or otherwise) to an attending provider to induce them to provide care in a manner inconsistent with the law. However, the Plan may negotiate the level and type of reimbursement with a provider.

NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996

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 newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

NOTICE OF PRIVACY PRACTICES

The Trust Fund maintains a Notice of Privacy Practices. The Notice explains the possible uses and disclosures of protected health information by the Trust Fund. It also outlines your rights in regard to your health information and the steps the Trust Fund has taken to protect health information and prevent unnecessary disclosures. A copy of the Notice of Privacy Practices can be found in your Plan Booklet or requested separately from the Trust Fund Office at the address or telephone number shown above.

GENETIC INFORMATION NONDISCRIMINATION ACT (GINA)

The Genetic Information Nondiscrimination Act (GINA) prohibits employers and other entities covered by GINA Title II from requesting or requiring genetic information of an individual or family member of the individual, except as specifically allowed by this law. “Genetic information,” as defined by GINA, includes an individual’s family medical history, the results of an individual’s or family member’s genetic tests, the fact that an individual or an individual’s family member sought or received genetic services, and genetic information of a fetus carried by an individual or an individual’s family member or an embryo lawfully held by an individual or family member receiving assistive reproductive services.

EXTENSION OF MEDICAL COVERAGE DURING TOTAL DISABILITY

If you or your covered dependents become Totally Disabled before your eligibility terminates, and do not choose to continue coverage under COBRA, benefits under the Major Medical Plan FOR ONLY THAT SPECIFIC DISABILITY will continue until the earliest of the following dates:

1. the date of recovery from that disability; or

2. the date of eligibility for benefits under any other Group Plan which has no limitations as to the disabling condition; or

3. a maximum of 12 months following the termination of eligibility.

Total Disability must be confirmed in writing by the attending physician.

LAPSE OF COVERAGE

Please note that a lapse of eligibility for health coverage lasting 3 consecutive months may cause you to owe an individual shared responsibility payment pursuant to the Affordable Care Act. The individual shared responsibility payment is due when you file your individual tax return.

You may avoid having to pay the individual shared responsibility payment by becoming covered under another health plan that qualifies as minimum essential coverage. Examples of minimum essential coverage include COBRA coverage offered by this Plan or a plan available through the Affordable Care Act Marketplace in your area.

More information about the individual shared responsibility provision can be found at the following IRS webpages:

- "Questions and Answers on the Individual Shared Responsibility Provision" http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/Questions-and-Answers-on-the-Individual-Shared-Responsibility-Provision

- "Individual Shared Responsibility Provision – Calculating the Payment" http://www.irs.gov/Affordable-Care-Act/Individuals-and-Families/ACA-Individual-Shared-Responsibility-Provision-Calculating-the Payment

FAMILY AND MEDICAL LEAVE ACT

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

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

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

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA)

YOUR HEALTH INFORMATION AND PRIVACY

The health benefit options offered under the Plan use health information about you and your Covered Dependents only for the purposes of providing treatment, paying claims, and related functions. The Plan's Privacy Notice is printed here.

To protect the privacy of health information, access to your health information is limited to such purposes. Effective April 14, 2003, the health benefit plan options offered under the Plan will comply with the applicable health information privacy requirements in Title II of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") and the applicable Federal regulations issued by the Department of Health and Human Services. Specific procedures related to the security of electronically transmitted Protected Health Information ("ePHI") effective April 20, 2005, are also described below.

PRIVACY RULE

The Plan has been amended to conform to the "Privacy Rule" as described as follows.

Use and Disclosure of Health Information.
The Plan may use your health information, that is, information that constitutes Protected Health Information ("PHI") as defined in the Privacy Rule of the Administrative Simplification provision of HIPAA, for purposes of making or obtaining payment for your care and conducting health care operations. The Plan has established a policy to guard against unnecessary disclosure of your health information.

THE FOLLOWING IS A SUMMARY OF THE CIRCUMSTANCES UNDER WHICH AND THE PURPOSES FOR WHICH YOUR HEALTH INFORMATION MAY BE USED AND DISCLOSED:

To Make or Obtain Payment. The Plan may use or disclose your health information to make payment to or collect payment from third parties, such as other health plans or providers, for the care you receive. For example, the Plan may provide information regarding your coverage or health care treatment to other health plans to coordinate payment of benefits.

The Plan may also disclose health information over the telephone to your spouse, another family member, or a personal representative (such as a Union business agent or Employer representative), for purposes of making or obtaining information about treatment or claims if you provide your oral authorization to the Plan to speak to this person on your behalf. If you do not wish the Plan to release your health information to your spouse, family member or personal representative without prior *written* authorization, please follow the instructions under the Right to Make Restrictions found in this notice.

To Conduct Health Care Operations. The Plan may use or disclose health information for its own operations to facilitate the administration of the Plan and as necessary to provide coverage and services to all Plan Participants. For example, the Plan may use your health information to conduct case management, quality improvement and utilization review, and provider credentialing activities or to engage in customer service and grievance resolution activities.

For Treatment. The Plan does not provide treatment. However, the Plan may use or disclose your health information to support treatment and the management of your care. For example, the Plan may disclose that you are eligible for benefits to a health care provider who contacts the Plan to verify your eligibility.

For Treatment Alternatives. The Plan may use and disclose your health information to tell you about or recommend possible treatment options or alternatives that may be of interest to you.

For Distribution of Health-Related Benefits and Services. The Plan may use or disclose your health information to provide to you information on health-related benefits and services that may be of interest to you.

Public Health Risks. The Plan may disclose medical information about you for public health activities. These activities generally include the following:

- To prevent or control disease, injury or disability.
- To report births and deaths.
- To report child abuse or neglect.
- To report reactions to medications or problems with products.
- To notify people of recalls of products they may be using.
- To notify a person who may have been exposed to a disease or may be at risk for contracting or spreading a disease or condition.
- To notify the appropriate government authority if the Plan believes a patient has been the victim of abuse, neglect, or domestic violence. The Plan will only make this disclosure if you agree or when required or authorized by law.

For Disclosure to the Plan Sponsor. The plan sponsor represents that adequate separation exists between the Plan and plan sponsor so that PHI will be used only for Plan administration. As a jointly trusteed multiemployer trust fund which contracts with a third-party administrator, the plan sponsor has no employees. No person under the control of the plan sponsor has access to your PHI. The Plan may disclose your health information to the plan sponsor for Plan administration functions performed by the plan sponsor on behalf of the Plan. Such administration shall include, but is not limited to, the following purposes appeals of adverse benefit determinations, financial oversight, data analysis, COBRA administration, coordination of benefits, and Plan design. The Plan also may provide summary health information to the plan sponsor so that the plan sponsor may solicit premium bids from other health plans or modify, amend, or terminate the Plan.

As a condition for obtaining PHI from the Plan and other insurers and HMOs participating in the Plan, the plan sponsor agrees to:

- Use or disclose any PHI received from the Plan only as permitted by the Privacy Rule or as required by law.
- Require each of its subcontractors or agents to whom the plan sponsor may provide PHI to agree to the same restrictions and conditions that apply to the plan sponsor with respect to PHI.
- Bar the use or disclosure of PHI for employment-related actions or decisions or in connection with any other employee benefit plans sponsored by the plan sponsor.
- Report to the Plan any use or disclosure of PHI that is inconsistent with the uses or disclosures authorized by the Privacy Rule of which it becomes aware.
- Make your PHI available for purposes of your request for inspection or copying.
- Make PHI available to the Plan to permit you to amend or correct PHI contained in the designated record set that is inaccurate or incomplete and incorporate such amendments as is allowed under the Privacy Rule.

- Make available the information required to provide an accounting of disclosures in accordance with the Privacy Rule.

- Make its internal practices, books and records relating to the use and disclosure of PHI available to the Plan and to the Secretary of the U.S. Department of Health and Human Services ("HHS") for the purpose of determining the Plan's compliance with the Privacy Rule.

- If feasible, return to the Plan or destroy all PHI received from the Plan in any form and retain no copies of such information when no longer needed for the purpose for which the disclosure was made. If return or destruction is not feasible, the plan sponsor agrees to restrict and limit further uses and disclosures to the purposes that make the return or destruction infeasible.

- Use best efforts to request only the minimum necessary type and amount of PHI to conduct the functions for which the information is requested.

When Legally Required. The Plan will disclose your health information when it is required to do so by any Federal, state, or local law.

Organ and Tissue Donation. If you are an organ donor, the Plan may release medical information to organizations that manage organ procurement or organ, eye or tissue transplantation or to an organ donation bank, as necessary to facilitate organ or tissue donation and transplantation.

To Conduct Health Oversight Activities. The Plan may disclose your health information to a health oversight agency for authorized activities including audits, civil administrative or criminal investigations, inspections, licensure, or disciplinary action. The Plan, however, may not disclose your health information if you are the subject of an investigation and the investigation does not arise out of or is not related to your receipt of health care or public benefits.

In Connection with Judicial and Administrative Proceedings. As permitted or required by state law, the Plan may disclose your health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order or in response to a subpoena, discovery request or other lawful process, but only when the Plan makes reasonable efforts to either notify you about the request or to obtain an order protecting your health information.

For Law Enforcement Purposes. As permitted or required by state law, the Plan may disclose your health information to a law enforcement official for certain law enforcement purposes, including, but not limited to, if the Plan has a suspicion that your death was the result of criminal conduct or in an emergency to report a crime.

To Coroners, Medical Examiners and Funeral Directors. The Plan may release your health information to a coroner or medical examiner. This may be necessary, for example, to identify a deceased person or determine the cause of death. The Plan may also release your health information to funeral directors as necessary to perform their duties.

In the Event of a Serious Threat to Health or Safety. The Plan may, consistent with applicable law and ethical standards of conduct, disclose your health information if the Plan, in good faith, believes that such disclosure is necessary to prevent or lessen a serious and imminent threat to your health or safety or to the health and safety of the public. Any disclosure would be to someone able to help prevent the threat.

For Specified Government Functions. In certain circumstances, Federal regulations require the Plan to use or disclose your health information to facilitate specified government functions related to the military and veterans, national security and intelligence activities, protective services for the President and others, and correctional institutions and inmates.

For Workers' Compensation. The Plan may release your health information to the extent necessary to comply with laws related to Workers' Compensation or similar programs.

In the Event of Your Death. If the individual is a decedent, the Plan may disclose the decedent's PHI (other than information about past, unrelated medical problems) to the decedent's family members and others who were involved in the care or payment for care of the decedent prior to the decedent's death, unless doing so would be inconsistent with any prior expressed preference of the individual that is known to the Plan.

For Underwriting and Related Purposes. The Plan may use or disclose your health information for the purposes of underwriting, premium rating, or other activities relating to the creation, renewal, or replacement of health insurance, but is prohibited from using or disclosing your genetic information for such purposes.

Authorization to Use or Disclose Health Information
Other than as stated above, the Plan will not disclose your health information without your written authorization. The Plan must obtain your authorization before using or disclosing your health information for marketing purposes or selling your information to a third party. If you authorize the Plan to use or disclose your health information, you may revoke that authorization in writing at any time.

YOUR RIGHTS WITH RESPECT TO YOUR HEALTH INFORMATION

You have the following rights regarding your health information that the Plan maintains:

Right to Request Restrictions. You may request restrictions on certain uses and disclosures of your health information. You have the right to request a limit on the Plan's disclosure of your health information to someone involved in the payment of your care. However, the Plan is not required to agree to your request. If you wish to make a request for restrictions, please contact the Privacy Officer at the Plan Administration Office.

Right to Receive Confidential Communications. You have the right to request that the Plan communicate with you in a certain way if you feel the disclosure of your health information could endanger you. You may be required to provide a statement that disclosure of your health information could endanger you. For example, you may ask that the Plan only communicate with you at a certain telephone number or by email. If you wish to receive confidential communications, please make your request in writing to the Privacy Officer at the Plan Administration Office. The Plan will attempt to honor your reasonable requests for confidential communications.

Right to Inspect and Copy Your Health Information. You have the right to inspect and copy your health information. A request to inspect and copy records containing your health information must be made in writing to the Privacy Officer at the Plan Administration Office. If you request a copy of your health information, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The Plan may deny your request in limited situations.

Right to Amend Your Health Information. If you believe that your health information records are inaccurate or incomplete, you may request that the Plan amend the records. That request may be made as long as the Plan maintains the information. A request for an amendment of records must be made in writing to the Privacy Officer at the Plan Administration Office. The Plan may deny the request if it does not include a reason to support the amendment. The request also may be denied if your health information records were not created by the Plan, if the health information you are requesting to amend is not part of the Plan's records, if the health information you wish to amend falls within an exception to the health information you are permitted to inspect and copy, or if the Plan determines the records containing your health information are accurate and complete.

Right to an Accounting. You have the right to request a list of disclosures of your health information made by the Plan for any reason other than for treatment, payment, or health operations. The request must be made in writing to the Privacy Officer at the Plan Administration Office. The request should specify the time period for which you are requesting the information but may not start earlier than April 14, 2003. Accounting requests may not be made for periods of time going back more than six (6) years. The Plan will provide the first accounting you request during any 12-month period without charge. Subsequent accounting requests may be subject to a reasonable cost-based fee. The Plan will inform you in advance of the fee, if applicable.

Right to a Paper Copy of this Notice. You have a right to request and receive a paper copy of this Privacy Notice at any time, even if you have received this Privacy Notice previously or agreed to receive the Privacy Notice electronically. To obtain a paper copy, please contact the Privacy Officer at the Plan Administration Office.

DUTIES OF THE PLAN

The Plan is required by law to maintain the privacy of your health information, to provide to you this Privacy Notice of its duties and privacy practices, and to notify you following a breach of your protected health information. The Plan is required to abide by the terms of this Privacy Notice, which may be amended from time to time. The Plan reserves the right to change the terms of this Privacy Notice and to make the new privacy practice provisions effective for all health information that it maintains. If the Plan changes its policies and procedures, the Plan will revise the Privacy Notice and will provide a copy of the revised notice to you within sixty (60) days of the change. You have the right to express complaints to the Plan and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated. Any complaints to the Plan should be made in writing to the Privacy Officer at the Plan Administration Office. The Plan encourages you to express any concerns you may have regarding the privacy of your information. You will not be retaliated against in any way for filing a complaint.

EFFECTIVE DATE

The Plan's privacy policies and procedures became effective April 14, 2003.

SECURITY RULE EFFECTIVE DATE

The following are the Plan's security rules with regard to the creation, receipt, maintenance, storage, and transmission of Protected Health Information ("PHI") via electronic means ("ePHI").

Use and Disclosure of ePHI. The Fund and its Plans may use and disclose ePHI, including ePHI for treatment, payment and operations, and such other uses and disclosures as are permitted and required under the HIPAA Privacy Rule and Security Rule, and the representatives of the Fund shall have access to such PHI, including ePHI, as is necessary for them to perform their duties for the Fund and its Plans.

Trustees' Use and Disclosure of ePHI. To the extent permitted by law, the Trustees may receive, use, and disclose ePHI, if, in the sole discretion of the Trustees, such ePHI is necessary for the Trustees to perform their fiduciary or administrative duties as Trustees. In all cases, the Trustees shall receive, use, and disclose the minimum amount of ePHI necessary for the Trustee to perform their functions under the Fund, and shall safeguard such ePHI as required by the Privacy and Security Rules. Each Trustee who receives ePHI from the Fund shall keep such information in strict confidence and shall not use or further disclose the ePHI received from the Fund other than as permitted or required by law and this Agreement or upon the express written permission of the Participant who is the subject of the ePHI.

Procedures. The Fund will implement administrative, physical, and technical safeguards that reasonably and appropriately protect the confidentiality, integrity, and availability of the ePHI that it creates, receives, maintains, or transmits on behalf of the Fund, and will ensure the "adequate separation" within the meaning of 45 C.F.R. §164.504(f)(2)(iii) of the data.

COMPLAINTS

If you wish to file a complaint with the Fund or have any questions regarding patient privacy and your privacy rights, you may contact the Privacy Officer at the following address:

Edward Simon, Privacy Officer
Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5065

A complaint may also be filed with the Department of Health and Human Services or its Office for Civil Rights, Hubert H. Humphrey Building, 200 Independence Avenue S.W., Washington, DC 20201.

All complaints must be in writing and filed within 180 days of the date you knew or should have known of the violation. This time limit can be waived if good cause is shown. The Fund will not retaliate against you for filing a complaint.

GENERAL ENROLLMENT INFORMATION

Enrollment Information and Procedure
It is necessary for all Employees eligible under this Fund to file a completed enrollment card with the Administrative Office to ensure prompt payment of claims and eligibility.

How to Enroll in the Medical Plan

1. Complete the Major Medical Plan's enrollment form which can be downloaded from the Fund's website at www.opeiufunds.org or contact the Administrative Office to request an enrollment form be mailed to you.

2. If you select the Kaiser Plan, you must complete the Kaiser enrollment application found in your Kaiser packet or you may download the Kaiser application from the Fund's website at www.opeiufunds.org or contact the Administrative Office to request a Kaiser enrollment form be mailed to you. Your enrollment cannot be processed without this form.

How to Enroll in the Dental Plan

1. For the Basic Dental Plan, complete the Basic Dental Plan enrollment form which can be downloaded from the Fund's website at www.opeiufunds.org or contact the Administrative Office to request an enrollment form be mailed to you.

2. For the United Concordia Pre-Paid Plan, complete the United Concordia enrollment form which can be downloaded from the Fund's website at www.opeiufunds.org or contact the Administrative Office to request an enrollment form be mailed to you. Be sure to fill in the provider number of the dental center you have selected.

SUBMIT ALL COMPLETED ENROLLMENT MATERIAL TO THE ADMINISTRATIVE OFFICE AS SOON AS POSSIBLE FOR IMMEDIATE PROCESSING.

REMEMBER - This is YOUR Health and Welfare Plan. In order to serve you most effectively, the Fund needs your assistance in these ways:

1. Be sure to file enrollment materials with the Trust Fund Office and KEEP IT UP TO DATE as to your dependents and address. Without up-to-date information, delays and unnecessary expenses may occur in the payment of claims.

2. Carry your medical identification card with you at all times. Be sure to show it to the admitting desk when entering a hospital, and to the doctor or nurse, on the FIRST office visit.

How to Enroll in Medicare
If you are approaching age 65, you are not automatically enrolled in Medicare unless you have filed an application and established eligibility for a monthly Social Security benefit. If you have not applied for Social Security benefits, you must file a Medicare application form during the three-month period prior to the month in which you become 65 years of age in order for coverage to begin at the start of the month in which you reach age 65. For enrollment and eligibility information, you may call Social Security at (800) 772-1213. You can also find Medicare information on the internet at www.medicare.gov.

ANNUAL OPEN ENROLLMENT

Open Enrollment is offered to all participants once each year in the month of January. During that period, you may change your health coverage to either of the two Medical Plans or two Dental Plans available. Notice of the upcoming Open Enrollment is mailed to all participants in December to be filed in January. The change will then become effective February 1st.

Dependents not previously enrolled may also be added during Open Enrollment. Their coverage will become effective February 1st.

The option of changing health coverage and/or adding dependents not previously enrolled is only available during Open Enrollment. If not elected at that time, you will not have another opportunity to make the change and/or dependent addition until the next Open Enrollment. In accordance with Health Reform regulations, you have the option to decline the Plan's dental and/or vision coverage. Note though that there is no additional benefit or compensation to you if you choose to decline/waive dental and/or vision coverage. If you decline dental and/or vision coverage you may re-enroll for such coverage at the next available open enrollment period.

Special Enrollment Rights
Although the collective bargaining agreements (CBA) do not allow you to decline enrollment for yourself or your dependents (including your spouse) because of other health insurance coverage, the law requires that the Plan inform you of your special enrollment rights.

If you become eligible for coverage through a new employer who does not contribute to this Trust Fund but you decline coverage under that new plan because of other group health coverage, and you later lose that other group health you may in the future be able to enroll yourself or your dependents in your employer's group health coverage, provided that you request enrollment within 30 days after your other coverage ends. In addition, if you have a new dependent as a result of marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself and your dependents, provided that you request enrollment within 30 days after the marriage, birth, adoption or placement for adoption. Call the Trust Fund Office if you would like more information about this right.

COVID-19 Extension of Deadlines
Due to the COVID-19 Pandemic, certain employee benefit plan deadlines that occur during the National Emergency that began on March 1, 2020 and will end 60 days after the announced end of the National Emergency (the "Outbreak Period") are extended. The Plan must disregard the Outbreak Period when determining deadlines for filing claims and appeals, special enrollment of new dependents or for electing COBRA coverage and payment of COBRA premiums.

By federal law, the period that is disregarded cannot exceed one year and will terminate as of the *earlier* of (a) 1 year from the date that an individual or plan is first eligible for relief, or (b) the end of the Outbreak Period (60 days after the announced end of the National Emergency). This period is referred to in this notice as the "Suspension Period." After the Suspension Period ends, the clock begins on any timeframe that started during the Suspension Period. If the timeframe began prior to the start of the National Emergency, the clock resumes running after the Suspension Period ends, and participants and beneficiaries will be permitted to use the remaining number of days they had prior to March 1, 2020.

The usual 30-day deadline to request enrollment in this Trust Fund following a special enrollment event (i.e., marriage, birth, adoption or placement for adoption of a child, or loss of other health coverage) has been suspended during the Suspension Period and will restart on the earlier of one year following the date of the special enrollment event or 60 days following the announced end of the National Emergency.

FUND OPERATION

The Fund Administrator is the Joint Board of Trustees

The Board of Trustees is as follows:

EMPLOYER TRUSTEES

Mr. Ron Miller
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5000

Mr. Rodney "Michael" Cobos
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5000

Mr. Leon Marzillier
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5000

Mr. Joel Barton
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5000

EMPLOYEE TRUSTEES

Ms. Jacqueline White-Brown
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5000

Ms. Marianne Giordano
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5000

Ms. Maribel Spillard
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5000

Ms. Laura Villegas
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5000

INFORMATION REQUIRED BY ERISA

The Employee Retirement Income Security Act of 1974 (ERISA), as amended, requires that certain information be furnished to each participant in an employee benefit plan, as follows:

Name of Plan
This Plan is known as the O.P.E.I.U. Locals 30 & 537 Health and Welfare Trust Fund.

Plan Identification Number
The Plan Identification Number is 95-6047601. This Plan was established and is maintained as a result of collective bargaining between Employers and Local Unions as determined by the Trustees. A copy of any such agreement may be obtained upon written request to the Fund Office or can be examined at the Fund Office during normal business hours. Upon written request participants and beneficiaries may also obtain information as to whether a participating employer or union is a sponsor of the Plan and that employer's or union's address.

Type of Plan
This Plan can be described as a plan which provides health and welfare benefits for eligible employees and their dependents.

Type of Administration
This Plan is administered by the Joint Board of Trustees with the assistance of:

The Plan Administrator at the Fund Office:
O.P.E.I.U. Locals 30 & 537 Health & Welfare Trust Fund
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906

The Agent for Service of Legal Process
Mr. Steven Rehaut and Mr. Joseph Paller Jr. of Gilbert & Sackman, a Law Corporation have been designated by the Trustees as agents for the purpose of accepting legal process. Their address is 3699 Wilshire Blvd, Suite 1200, Los Angeles, CA 90010. Service of legal process may also be made on any member of the Board of Trustees.

The Fund is sponsored by a joint Labor-Management Board of ten (10) Trustees. Half the Board members represent the participating Union, which is the Office and Professional Employees International Union Locals No. 30 and No. 537, AFL-CIO, CLC, and half represent participating employers. The name, address and telephone number of the Board is:

Board of Trustees of the O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund
c/o Benefit Programs Administration
1200 Wilshire Blvd., Fifth Floor
Los Angeles, CA 90017-1906
(562) 463-5065

Sources of Plan Benefits
Hospital and medical benefits are paid by the Trust Fund unless you have enrolled in Kaiser. If you are enrolled in Kaiser, the Trust Fund pays a monthly premium to Kaiser on your behalf and Kaiser is financially responsible for your claims. Prescription drug benefits are administered by Express Scripts and paid by the Trust Fund. Dental benefits for the Basic Dental Plan are paid by the Trust Fund. If you are enrolled in United Concordia, the Trust Fund pays a monthly premium to United Concordia on your behalf and United Concordia is financially responsible for your claims. Vision care benefits are administered by VSP and paid by the Trust Fund unless enrolled in Kaiser, then Kaiser is financially responsible for your vision claims. Life insurance and Accidental Death and Dismemberment benefits are paid through an insurance policy between the Fund and Unimerica. "Financially responsible" mentioned above means net of participant deductibles and copays (if any).

Addresses for the providers mentioned above are as follows:

Kaiser Foundation Health Plan
3100 Thornton Avenue, 3rd Floor
Burbank, California 91504

Express Scripts
One Express Way
St. Louis, Missouri 63121

United Concordia
21700 Oxnard Street, Suite 500
Woodland Hills, California 91367

Vision Service Plan
3333 Quality Drive
Rancho Cordova, California 95670

Unimerica (a UnitedHealth Company)
2300 Clayton Road, Suite 1000
Concord, California 94520

Sources of Contributions to the Plan
The employer contributions and employee self-payments are received and held in trust by the Board of Trustees pending the payment of claims, premiums, and administrative expenses.

Plan Year
This Fund is on a February 1st - January 31st fiscal year basis. For benefit purposes, the deductible accumulation period is on a calendar year basis (January 1 through December 31).

This booklet is a Summary Plan Description required by federal law. Every effort has been made in this summary to fully and accurately summarize your benefits and the rules and regulations of the Fund. A summary of the Annual Report of the Fund is furnished to you yearly by the Plan Administrator.

IMPORTANT
This Summary Plan Description is subject to the provisions of the Trust Agreement and cannot modify or affect the Trust Agreement in any way; nor shall you accrue any rights because of any statement in or omission from the Summary Plan Description.

DESCRIPTION OF BENEFITS

MAJOR MEDICAL BENEFITS COVERED EXPENSES

Covered expenses are the usual, customary, and reasonable medical charges which are subject to the EXCLUSIONS, LIMITATIONS, DEFINITIONS and all provisions of this Plan. Covered expenses are further defined as expenses incurred by an eligible Participant for the following which are approved by a Doctor and are reasonably necessary for the care and treatment of a covered sickness and/or injury.

1. Local, surface ambulance transportation to and from the nearest hospital where care and treatment of the illness and injury can be given.

   If you receive Air Ambulance services that are otherwise covered by the Plan from an out-of-network provider, those services will be covered by the Plan as follows:

   (a) The Air Ambulance services received from an out-of-network provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by an in-network provider.

   (b) In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by an in-network provider of Air Ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.

   (c) Any cost-sharing payments you make with respect to covered Air Ambulance services will count toward your in-network out-of-pocket maximum in the same manner as those received from an in-network provider.

2. The charges made by an anesthesiologist and/or anesthetist for the administration of anesthesia.

3. The charge for blood and blood plasma (if it is not replaced).

4. Diagnostic, laboratory, sonography, radium and radioisotope and x-ray expense.

5. The charges for the rental of a wheelchair, hospital bed; other durable mechanical equipment up to the purchase price of the item, subject to the approval of the Board of Trustees of this Fund.

6. The charges made by an extended care (skilled nursing) facility (limited to a 60-day maximum per disability) when such confinement:

   (a) is preceded by confinement of at least three (3) days in a hospital.

   (b) is for the same condition causing the preceding confinement.

   (c) commences within 7 days after discharge from such confinement.

7. The charges made by a hospice for hospice care only if:

   (a) the expense is incurred by a covered person diagnosed by a Doctor as terminally ill with a prognosis of 6 months or less to live; and

(b) the hospice provides a plan of care which:

(1) is prescribed by the Doctor

(2) is reviewed and approved by the Doctor monthly

(3) is not for any curative treatment; and

(4) states the belief of the Doctor and hospice that the hospice care will cost less in total than any comparable alternative to hospice care.

Hospice care includes services and supplies furnished by a Home Healthcare Agency as well as palliative and supportive medical nursing services.

8. The charges made by a licensed hospital, while the patient is a registered bed patient, for daily room and board, and limited to amounts shown in the Schedule of Benefits.

9. The charges made by a hospital for services and supplies.

10. Charges made by a licensed hospital or ambulatory surgery center for services and supplies furnished for outpatient care.

11. The charges made by a Registered Graduate and/or a Licensed Vocational Nurse for private duty nursing in a hospital or at home when need is certified by a physician. In a hospital, when the need is certified by the hospital administrator and/or the Head of the Nursing Service.

12. Oxygen and services/supplies for administration of oxygen.

13. The charges for professional services of a licensed Physical Therapist including acupuncture services (limited to 30 visits per calendar year per illness).

14. The charges made by a Doctor for medical treatment. However, charges for services:

(a) by a **Podiatrist** are limited to 10 visits per calendar year.

(b) by a **Chiropractor** are limited to 30 visits per calendar year.

(c) for treatment of morbid obesity are limited to one course of treatment per lifetime.

(d) Notwithstanding any provision to the contrary, the Plan will provide coverage for obesity to the extent it consists of medically necessary treatment of a mental health or substance use disorder. For this purpose, “medically necessary treatment of a mental health or substance use disorder” means a service or product addressing the specific needs of that patient for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

(1) In accordance with the generally accepted standards of mental health and substance use disorder care.

(2) Clinically appropriate in terms of type, frequency, extent, site, and duration.

(3) Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider.

15. Pregnancy expenses of employee or spouse.

16. The charges for drugs, medicines, and injections lawfully obtainable only upon the written prescription of a Physician. This includes contraceptive drugs (other than drugs to induce abortions) and devices.

17. The charges for *initial* artificial limbs or eyes required to replace natural limbs or eyes while an eligible Participant is covered hereunder.

18. The charges incurred for a medical examination which results in a hearing device(s) being prescribed, will be reimbursed at 80% of the expenses incurred for the examination and hearing device(s) to a maximum of $1,000 in a 3-year period. Benefits are not payable for battery replacements, or repair and maintenance, or for device(s) obtained more than 90 days after the examination prescribing the device.

19. Sterilization procedures (this is an exception to the requirement that a Covered Expense be for treatment of illness or injury).

20. The charges for casts, trusses, braces, crutches, and surgical dressings.

21. Therapeutic and elective abortions of employee or spouse (the latter is also an exception to the requirement that a Covered Expense be for treatment of an illness or injury).

22. Charges for immunizations and inoculations. This includes all vaccinations and flu shots. Deductible does not apply to this benefit.

23. Preventive care, screenings and immunizations as recommended by the U.S. Preventative Services Task Force that also includes:

    (a) Evidenced-based items or services that have in effect a rating of “A” or “B” in the current recommendations of the United States Preventive Services Task Force (USPSTF) with respect to the individual involved.

    (b) Immunizations for routine use in children, adolescents, and adults that have in effect a recommendation from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC) with respect to the individual involved.

    (c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration (HRSA); and

    (d) With respect to women, evidence-informed preventive care and screening provided for in comprehensive guidelines supported by HRSA, to the extent not already included in certain recommendations of the USPSTF.

    (e) All Food and Drug Administration–approved contraceptive methods prescribed by a woman’s doctor including:

        (1) Barrier methods, like diaphragms and sponges.
        (2) Hormonal methods, like birth control pills and vaginal rings.
        (3) Implanted devices, like intrauterine devices (IUDs).
        (4) Emergency contraception, like Plan B and ella.
        (5) Sterilization procedures.
        (6) Patient education and counseling.

    Note: Not covered drugs to induce abortions or services related to a man’s reproductive capacity, like vasectomies.

If a recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Fund will use reasonable medical management techniques to determine any coverage limitations.

Please note: To help you stay healthy, participants in the Major Medical Plan (PPO) can receive vaccinations conveniently administered at your participating retail pharmacy through your Express Scripts prescription plan. This program allows both you and your enrolled dependents to receive vaccinations with a $0 copayment.

Before you visit the Pharmacy…

- Make sure the pharmacy you use is part of your Express Scripts participating pharmacy network. If you're not sure, login to express-scripts.com and click "Find a pharmacy" from the menu under "Prescriptions" to find out. You can also use the Express Scripts mobile app on your digital device to locate a participating pharmacy.

- Call the pharmacy to verify their current vaccination schedule, ask your pharmacist which vaccines are right for you, and check on vaccine availability and age restrictions.

- When You Get to the Pharmacy…

- Be sure to present your prescription member ID card at the time of service.

- Be sure to get your vaccine from the pharmacist at the pharmacy, not from the pharmacy's on-site clinic.

Express Scripts provides prescription drugs for you and your enrolled dependents. Prescriptions must be filled at pharmacies contracted with Express Scripts. A list of network pharmacies can be found on the Express Scripts Web site at http://www.express-scripts.com. You can also contact Express Scripts by phone at (800) 606-5667.

24. Bone Density Testing for those:

(a) Who are at least age 50, and

(b) (1) Who suffer from osteodystrophy or osteoporosis, or
(2) Estrogen deficient women at clinical risk for osteoporosis, or
(3) Members with vertebral abnormalities, or
(4) Members with hyperparathyroidism.

These tests must be ordered by a physician and must fall under procedure codes 76075, 76076 or 76078. These screening tests are covered at health care facilities only (not at health fairs or drugstores, as examples).

25. Mastectomies when medically necessary, and:

(a) Reconstruction of the breast on which the mastectomy was performed.

(b) Surgery and reconstruction of the other breast to produce a symmetrical appearance; and

(c) Prostheses and physical complications of all stages of mastectomy including lymphedemas.

26. Clinical Trial benefits (please contact the Trust Fund Office for details on approved guidelines).

27. COVID-19 Testing

Cost sharing is waived for COVID-19 testing and related provider visits. This means that there will be no copays, coinsurance or deductible applied to physician-ordered diagnostic tests for COVID-19 and related medical provider visits for COVID-19 screening at doctor's office, telemedicine visit, urgent care, etc. Out of network, physician-ordered diagnostic tests for COVID-19 and related medical provider visits for COVID-19 screening will be reimbursed in accordance with the applicable law, but the Trust encourages you to always use network providers when possible.

Effective January 15, 2022, the Plan will cover the cost of over-the-counter, at-home COVID-19 diagnostic tests authorized by the FDA, with no cost to you, subject to the eight (8) count limit, as long is the test is intended for personal use, to diagnose or treat COVID-19. You do not need a referral from a doctor or a prior authorization from the Plan to be reimbursed for the cost of these tests. The Plan will not cover the cost of tests purchased for employment purposes, such as a test your employer requires you to take before returning to work from a long weekend. The Plan will also not cover the costs of tests for surveillance purposes, such as tests taken to attend a social gathering or for travel.

For additional details and questions related to Over the Counter (OTC) COVID-19 Test reimbursement please contact the Trust office at please contact the Trust office at (562) 463- 5065 or the website at www.opeiufunds.org.

If you are enrolled in Kaiser, please check with Kaiser regarding how you may obtain test kits and get reimbursed for them.

You can also obtain tests completely free through the Government COVID-19 at home testing website: https://www.covidtests.gov/.

This waiver of cost sharing applies to items and services that were furnished on or after March 18, 2020 and continues to apply for the duration of the COVID-19 public health emergency. Unless it is extended or terminated early, the current COVID-19 public health emergency is set to expire on March 1, 2023 unless ended by earlier by the federal government.

If a participant is diagnosed with COVID-19, all treatment including but not limited to hospital, transportation and pharmacy services will be covered in accordance with the terms and conditions of the Plan.

MAJOR MEDICAL PLAN LIMITATIONS AND EXCLUSIONS

No benefits of any kind shall be payable for expense incurred for:

1. Whole blood or plasma when such is donated or otherwise replaced.

2. Cosmetic surgery, or any complications resulting therefrom at any time in the future, unless necessitated by a non-occupational accidental bodily injury and then only for Covered Expenses incurred within one year from the date of the non-occupational accidental injury. This exclusion does not apply to treatment or surgery to alleviate a condition resulting from a congenital defect affecting bodily function.

3. Custodial care, or domiciliary care or care in an institution, primarily a place of rest, for the aged, nursing home or any like institution. As further consideration for the Board of Trustees, the term, "Custodial Care" shall have the same meaning as contained in the federal Dependents' Medical Care Act, commonly known as "CHAMPUS," and regulations implementing that Act and the definition of custodial care contained therein.

4. Dental Expenses - There shall be no benefit payment under these Medical Benefits in connection with any treatment on or to the natural teeth or for malocclusion except for the repair or alleviation of damage caused solely by accidental bodily injury and provided such treatment is rendered to the eligible Participant within one year after such accident.

5. Services, supplies and benefits for which an eligible Participant is entitled (or would have been entitled if proper application had been made) for any hospital, medical, dental or disability benefit paid by, reimbursed by or furnished by or payable under any Plan, authority or law of any Government or Government Agency Federal or State, Dominion or Province or any political subdivision thereof.

6. Benefits for which no charge is made or for which an eligible Participant is not required to pay or is not billed nor would have been billed except for the fact that he/she has "insurance."

7. Charges in excess of the fees and prices generally charged in the community for services or supplies generally furnished with respect to the accidental bodily injury or sickness being treated. See definition of Allowable Charges.

8. Any service rendered to an eligible Participant by a spouse, child, brother, sister, parent or grandparent, or in-laws.

9. Eye refractions, glasses or contact lenses and related examinations including orthoptics or other visual training. Eye examinations for the purpose of prescribing corrective lenses, eyeglasses or contact lenses, including the fitting thereof, except as provided under the separate Vision Care Program through VSP.

10. Fetal Monitoring (including uterine monitoring) - charges for fetal monitoring and all attendant charges, which include, but are not limited to, the rental or purchase of the monitoring device, telephone fees for transmitting data, if any, professional fees for reading and interpreting the data, and any and all associated inpatient charges except for monitoring services performed at full term delivery.

11. Routine inpatient newborn care expenses are not covered, other than those necessary for the treatment of sickness or bodily injury of such infant. Circumcision is not a covered benefit.

12. Non-occupational accidental bodily injury or non-occupational sickness for which the person on whom claim is presented is not under the regular care of a Doctor, and for services, supplies or treatment, including any period of hospital confinement, which were not recommended, approved, and certified as necessary and reasonable by a Doctor based upon a prescription evaluation.

13. Any bodily injury, sickness, or dental condition for which the person on whom claim is presented has or had a right to compensation under any Workers' Compensation, Occupational Disease Law or any other legislation of similar purpose, or any bodily injury or sickness which arises from or is sustained in the course of any occupation or employment for compensation, profit or gain.

14. Personal comfort or beautification items.

15. Transportation, except local professional ambulance service.

16. Treatment for alcoholism or drug addiction.

17. Hypnotherapy; group mental health therapy, marriage, and family counseling.

18. Biofeedback, hypnosis therapy, or pain clinics.

19. Any charges resulting from or related to any drug, device, medical or surgical procedure which is considered by the Fund to be experimental or investigative in nature. A drug, device, medical treatment, or procedure is experimental or investigative:

    (a) if the drug or device cannot be lawfully marketed without approval of the U.S. Food and Drug Administration and approval for marketing has not been given at the time the drug or device is furnished; or

    (b) if the drug, device, medical treatment or procedure, or the patient informed consent document utilized with the drug, device, treatment, or procedure, was reviewed and approved by the treating facility's Institutional Review Board or other body serving a similar function, or if federal law requires such review or approval; or

    (c) if Reliable Evidence shows that the drug, device, medical treatment, or procedure is under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis; or

    (d) if Reliable Evidence shows that the prevailing opinion among experts regarding the drug, device, medical treatment, or procedure is that further studies are necessary to determine its maximum tolerated dose, its toxicity, its safety, its efficacy or its efficacy as compared with a standard means of treatment or diagnosis.

    Reliable Evidence shall mean only published reports and articles in the authoritative medical and scientific literature; the written protocol or protocols used by the treating facility or the protocol(s) of another facility studying substantially the same drug, device, medical treatment or procedure; or the written informed consent used by the treating facility or by another facility studying substantially the same drug, device, medical treatment or procedure.

20. Any injury inflicted by an eligible Participant to any other eligible Participant other than by accidental means; or any injury resulting from or occurring during the commission or attempt to commit an assault or felony; or any injury resulting from an eligible Participant being in an illegal occupation.

21. Services required due to insurrection, war (declared or undeclared), or any act of war and any complication therefrom.

22. Treatment by any method for jaw joint problems including temporomandibular joint syndrome (TMJ) and craniomandibular disorders, or other conditions of the jawbone, skull, complex of muscles, nerves and other tissues related to that joint.

23. Hospitalization primarily for physical therapy or other rehabilitative care; hospitalization primarily for x-rays, laboratory, or other diagnostic studies, except where such services cannot be rendered safely and adequately on an outpatient basis.

24. Treatment of obesity; any treatment for overweight problems resulting from overeating. In cases where a true endogenous or pathological glandular (endocrine) disturbance is established as the cause, benefits are limited to one course of treatment per lifetime, subject to review by the Fund's Medical Consultant. **All** treatment for obesity **must** be preauthorized in writing by the Trust Fund Office prior to the initiation of treatment. **The Major Medical Plan <u>will not provide</u> benefits for any services that are not preauthorized**. Treatment for morbid obesity (defined as a Body Mass Index of 40 or more) is also subject to review and preauthorization. Refer to item 14(c) on page 51.

25. Surgical procedures to attempt restoration of continuity of a previous vasectomy or vas ligation, or tubal ligation, transection, or destruction for any reason.

26. Organ transplants except kidney transplant and hemodialysis treatment. Expenses incurred by an organ donor will not be considered a Covered Expense nor will charges be covered for transportation, meals, or lodging.

27. Charges incurred which are incidental to myopia surgery, radial keratotomy, or any other type of corrective surgery for myopia, except if necessary to prevent permanent and total loss of vision.

28. Nutritional and weight control programs.

29. Equipment in common use for other than medical purposes.

30. Vitamins, minerals, food supplements, digestive enzymes and substances, natural animal or vegetable substances, bacterial, viral substances, or homeopathic preparations.

31. Occupational Therapy and Speech Therapy for any illness or injury.

32. Treatment of developmental disorders regardless of the cause including medical care, physiotherapy, occupational therapy, speech therapy, and educational services. This exclusion includes autistic disease of childhood, hyper kinetic syndromes, learning disabilities, behavioral problems, mental retardation, and hospitalization for environmental change. Exceptions to these exclusions include preventive autism screening at ages 18 and 24 months and certain behavioral assessments for children.

33. Hospital expenses incurred for any dental procedure (covered or not covered) performed.

34. Pregnancy and abortion (therapeutic and elective) for dependents other than spouses.

35. Services and supplies associated with treatment for infertility/impotency. Sterilization reversal, artificial insemination or invitro fertilization.

36. Allowable Charges for routine mammograms will be covered no more than once per year for women age 40 to 75. Routine annual mammograms will also be covered for women younger than age 40 who have a mother or sister who has been diagnosed with breast cancer.

37. Allergy testing - skin testing and antigen extracts are covered. No other services related to allergy testing or treatment are covered.

38. Homeopathic or holistic treatment.

39. Fees for medical records or legal records.

40. Charges for breast implants, the removal of breast implants or any complication at any time resulting therefrom.

41. Penile implants unless required as a result of injury or an organic disorder.

42. Genetic testing to establish paternity of a child or tests to determine the sex of an unborn child.

43. Bone marrow transplants.

44. Air conditioners, humidifiers, or purifiers.

45. Claims not submitted within 12 months after expenses were incurred, except in absence of legal capacity. Additional information requested by the Trust Fund Office on behalf of the Board of Trustees that is not submitted in a timely manner may delay or deny payment.

46. Fees to complete claim forms.

47. Any other services not specifically covered by the Major Medical Plan.

48. Services or supplies rendered when, at the sole and absolute discretion of the Board of Trustees, are not considered to be medically necessary.

49. Charges for missed or broken appointments.

50. Any supplies or services: (1) for which no charge is made; or (2) for which the Participant is not required to pay in the absence of this Major Medical Plan; or (3) furnished by a hospital or facility owned or operated by the United States Government or any State Government or any authorized agencies thereof or furnished at the expense of such Governments or agencies except as required by federal law; or (4) which are provided without cost by any municipal, county or other political subdivision; or (5) court-ordered care.

51. Care or treatment in any penal institution or jail facility or jail-ward of any State or political subdivision.

52. Any care or treatment performed by a provider not specifically covered under the Major Medical Plan, regardless of whether or not the provider is licensed to perform such treatment, including, but not limited to, a marriage, family and child counselor or a licensed clinical social worker.

53. Charges for expenses incurred outside the United States unless when traveling and in need of urgent or emergency care.

54. Any surgical procedure or other treatment for complications of a procedure which is excluded under the Plan.

55. Outpatient prescription drugs and self-administered injectables (please refer to the Prescription Drug Benefits Section starting on page 66).

MAJOR MEDICAL PLAN COST CONTAINMENT PROGRAMS

A. PRE-ADMISSION AND CONCURRENT REVIEW PROGRAM

Administered by AETNA

Hospital Pre-Admission Notice and Hospital Services Concurrent Review are aspects of your Major Medical Plan which are designed to help you avoid unnecessary hospitalization and surgery, reduce hospital costs, and protect your benefits.

The Major Medical Plan requires prior notice of all non-emergency hospitalizations. This can help you avoid the discomfort and expense of a hospitalization when an alternative is available. This approach also encourages your Doctor and the Hospital to let you go home, where it is comfortable and familiar as soon as your health allows.

The Hospital Admissions Review Program is simple and convenient for you to use. **When hospitalization is discussed with you, inform your doctor of the Major Medical Plan's hospital pre-admission review notice. Your doctor must contact AETNA at 1-888-632-3862 to initiate the review proceedings.** In the case of an emergency, a telephone call by the doctor or hospital within twenty-four (24) hours to AETNA at the above number after you have been admitted is all that is required.

Your immediate notice to AETNA of hospitalization will permit the maximum benefits for hospital services covered under the Major Medical Plan. On the other hand, if you enter the hospital without meeting the Major Medical Plan's notice requirements, or if AETNA is not notified within twenty-four (24) hours of an emergency admission, you risk lower payment under the Major Medical Plan.

To help keep down the cost of hospital care, all admissions will be reviewed during your stay to determine whether continued hospitalization is medically necessary ("concurrent review").

Major Medical Plan Coverage 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 normal vaginal delivery, or less than 96 hours following a Caesarean Section, or require that a provider obtain authorization from the Plan for prescribing a length of stay not in excess of the above periods.

IF YOU DO NOT OBTAIN PRE-ADMISSION REVIEW OR INITIATE CONCURRENT REVIEW, COVERAGE FOR ALL COVERED CHARGES INCURRED WILL BE REDUCED BY 30%.

EMERGENCY-ADMISSION REVIEW

Admissions that cannot be scheduled in advance, such as emergencies, are evaluated when you are admitted to be certain that the admission is medically necessary under the terms of the Major Medical Plan.

The Plan will not impose more restrictive administrative requirements on out-of-network Emergency Services than in-network ones.

CLAIMS (RETROSPECTIVE REVIEW)

Claims for all admissions that are not certified as medically necessary will be reviewed to determine whether all or part of the stay will be covered. If you have additional questions, please call the Trust Fund Office at (562) 463-5065 or (800) 386-4350.

B. OUTPATIENT SURGICAL AND DIAGNOSTIC REVIEW PROGRAM
Administered by AETNA

The Outpatient Surgical and Diagnostic Review Program is designed to help you avoid unnecessary surgery, reduce costs, and protect your benefits. You will, in turn, receive a free independent professional review.

When outpatient surgical procedures and diagnostic tests are discussed with you, inform your doctor of the Major Medical Plan's Outpatient Service Review Program. Your doctor must contact AETNA at 1-888-632-3862 to have certain procedures or diagnostic tests pre-authorized.

IF YOU DO NOT RECEIVE AN OUTPATIENT SERVICE REVIEW WHEN REQUIRED AND BEFORE SERVICES ARE PROVIDED, YOUR BENEFITS UNDER THIS MAJOR MEDICAL PLAN WILL BE REDUCED BY 30%.

C. MEDICAL CASE MANAGEMENT PROGRAM
Administered by AETNA

Extensive, long-term treatment and/or potentially high-cost care may be subject to AETNA's Medical Case Management Program. Case management assures that the Participant obtains quality medical care by the most cost-effective use of health care resources. Medical case management services seek alternative settings and providers, coordinate the sequence of care by facilitating communications among providers and patient, and perform continuous monitoring of care. AETNA will notify your Doctor, if necessary, to initiate assistance under this program.

BENEFIT SUBSTITUTION POLICY
In some instances, a participant's medical needs may be best met by offering a service or supply which is not normally covered by the Major Medical Plan. When this is the case, the service or supply will be covered by the Major Medical Plan only if:

1. the service or supply is provided in lieu of a more costly service or supply which is covered by the Major Medical Plan; and

2. the benefit substitution is recommended by AETNA and approved by the Board of Trustees.

ADDITIONAL AETNA FEATURES

AETNA Member Website
The AETNA member website is a secure member website that's available, 24/7. The AETNA member website can be accessed by logging onto www.aetna.com. Select "Log-In/Register" and follow the simple steps to either set-up or access your AETNA member website account. Initial registration will require your Member ID#. All of members' health benefits and health insurance plan information and cost-savings tools are in one place. Once you sign up, you can:

- Find a doctor or facility
- Compare cost estimates for health care services
- Compare hospital facility rates and quality and learn average medical care costs for the area
- View deductible and plan limits
- View summary of coverage and benefits
- Save on health-related products and services
- Store and share personal health history
- Track your health goals
- Find forms and view/print ID cards
- Ask Ann, AETNA's Virtual Assistant.

AETNA Mobile Apps
AETNA Mobile shows a streamlined view of the AETNA member website. You can access AETNA's most popular tools directly from the AETNA Mobile app available from App Store and Play Store.

Supported Devices

- Android
- iPhone, iPod Touch and iPad

How to Access

- Android: Go to Play Store and search for AETNA Mobile.
- iPhone: Go to App Store and search for AETNA Mobile.
- Text **apps** to **23862** to download.

AETNA'S 24-Hour Nurse line
AETNA's Informed Health Line (IHL) gives members ready access to registered nurses who can answer their questions on a variety of health topics. Members can reach these nurses on a 24/7 basis via a toll-free phone number or through an email link on their AETNA Navigator page. The toll-free phone number is 1-800-556-1555.

Teladoc
Teladoc is an affordable, more convenient, and timelier alternative to Emergency Room (ER) and Urgent Care (UC) center visits for non-emergency medical care. Using Teladoc can be convenient by preventing the need to arrange for transportation or travel, childcare, and time off from work just to visit a doctor. Note that Teladoc is not designed to replace a Primary Care Physician (PC) relationship, but rather supplement a member's access to care as an additional and more efficient option.

Teladoc offers members the ability to consultant with a national network of U.S. board-certified family practitioners, PCPs, pediatricians, and internists to diagnose, recommend treatment, and write short-term (non-DEA prescriptions), when necessary. Consultations are available by telephone as well as by online video using Teladoc.com or through the Teladoc Member mobile app. Teladoc can provide effective resolution to a wide range of common and routine illnesses helping prevent unnecessary use of the ER or urgent Care centers. The Teladoc phone number is (855) 835-2362.

Note:

- Effective June 1, 2020, Teladoc visits are offered at $0 copay
- No controlled substances, psychiatric or lifestyle drugs will be prescribed by Teladoc.

AETNA Discount Program
The **AETNA Discount Program** offers you discounts on a wide variety of products and services for your health, your wellness and your life that may not be directly covered by the Plan. There are no extra costs for members to take advantage of the discounts. There are no claim forms or referrals and no limits on how often you can use the.

BASIC DENTAL PLAN PROGRAM

This program is self-funded under the O.P.E.I.U. Locals 30 & 537 Health and Welfare Trust Fund. The Trustees urge you and your dependents to use the Basic Dental Plan only when needed. This is your program; we therefore request your help and cooperation in curbing any abuse which might tend to have an adverse effect on the Fund.

Coverage Provided
The Basic Dental Plan has a $50 annual deductible with a maximum amount payable per calendar year of $2,200 (maximum does not apply for children under age 19). Orthodontics has a separate $2,200 maximum lifetime benefit. Benefits payable under the Plan depend on the services and supplies provided by the dentist. The schedule of coinsurance, the maximum fees allowed, and allowable procedures are outlined in the Table of Allowances, which is provided automatically without cost to those enrolled under the Basic Dental Plan. If you do not receive yours automatically, please contact the Trust Fund Office for your free copy of the Table of Allowances.

Participation in Plan
Employees are entitled to participate in the Plan if they work under one of the Collective Bargaining Agreements that provides that their employer make contributions to the Fund on their behalf. There is no age or years of service requirement for participation. Also, certain non-bargaining unit employees are entitled to participate pursuant to special agreements between their employers and the Board of Trustees.

Source of Contributions
This Plan is funded through employer contributions, the amount of which is specified in the underlying Collective Bargaining Agreements. Also, self-payments by Employees are permitted if an Employee has qualified for dental coverage prior to discontinuation of employer contributions. A full monthly contribution at a rate determined by the Board of Trustees is required to maintain eligibility.

Pre-Certification
Pre-certification is strongly suggested when services will exceed $500 or when gold is to be used. Have your dentist call (562) 463-5065 or (800) 386-4350. Certification will be valid for 90 days providing eligibility does not terminate during that period. Failure to obtain pre-certification may result in your not being covered for the treatment.

DENTAL LIMITATIONS AND EXCLUSIONS

This Basic Dental Plan does not pay expenses for:

1. More than one oral examination or prophylaxis during any period of six consecutive months (180 days).

2. Dental procedures for cosmetic reasons, unless performed within two years after an accident to repair or alleviate damage from that accident which occurred while covered.

3. Temporary full prosthesis. The term "prosthesis" means any crown or any fixed or removable denture.

4. Replacement of an existing prosthesis which, in the opinion of the attending Doctor, is or can be made satisfactory.

5. Replacement of a prosthesis, except a crown necessary for restorative purposes only, for which benefits were paid under this Plan if the replacement occurs within five years from the date the expense was incurred, unless: (a) the replacement is made necessary by the initial placement of an opposing full prosthesis or the extraction of natural teeth, or (b) the prosthesis is a stay plate or similar temporary partial prosthesis, and is being replaced by a permanent prosthesis, or (c) the prosthesis, while in the oral cavity, has been damaged beyond repair as a result of injury while covered.

6. Any procedures which began before the date the covered person became eligible under this Plan or began after the individual ceased eligibility. Any supplies furnished in connection with such procedure, except that x-rays and prophylaxis treatment will not be considered as the beginning of a dental procedure.

7. Replacement of a lost or stolen appliance.

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

9. Procedures which are necessary solely to increase vertical dimension or restore the occlusion.

10. Adjustments or relining of a prosthesis within six months after the prosthesis is initially furnished.

11. Any treatment by any method for temporomandibular joint dysfunction (TMJ).

12. Any services rendered by a member of the immediate family of the person or of the person's spouse.

13. Any orthodontia treatment which is not pre-authorized.

14. Hospital expenses incurred for any dental procedure performed (covered or not covered).

15. Implantology.

16. Separate charges for Analgesia and/or Nitrous Oxide (except for general anesthesia given by a dentist for covered oral surgery procedures).

17. Any charge above allowable charges or for a procedure determined not to be necessary dental treatment as determined by the Board of Trustees.

18. Charges for completion of claim forms.

19. Charges for missed or broken appointments.

20. Claims not submitted within 12 months after expenses were incurred, except in absence of legal capacity. Additional information requested by the Trust Fund Office on behalf of the Board of Trustees that is not submitted in a timely manner may delay or deny payment.

21. Charges for expenses incurred outside the United States unless when traveling and in need of urgent or emergency care.

22. The replacement of a crown which was covered under this Plan, if such replacement occurs within five years from the date expense was incurred.

23. The amount of benefits payable by this Plan and any other Plans will be coordinated so that the aggregate amount paid will not exceed the amount that would be paid if this Plan were the primary payer. The O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund payment will not exceed the amount which would have been paid if there were no other Plan involved.

PRESCRIPTION DRUG BENEFIT FOR MAJOR MEDICAL PLAN PARTICIPANTS

The Fund has contracted with Express Scripts to provide prescription drugs for eligible participants enrolled in the Major Medical Plan. A copayment of $20 for generic and $30 for a brand name prescription will be charged.

Prescription coverage is also available at non-Express Scripts pharmacies; payable through the Trust Fund at 60% of reasonable and customary charges after satisfaction of the $700 major medical plan annual deductible for covered medical expenses.

A participant may obtain prescription drugs through Express Scripts in two ways. One is by using the Express Scripts prescription drug card. It is honored at over 60,000 pharmacies throughout the country (including the major chains). The other is Express Scripts' Mail Service prescription program which is set up to dispense up to a 90-day supply of maintenance medications which are generally needed for chronic medical conditions.

It is recommended that you use the Express Scripts drug card for your immediate prescription needs. It allows you to receive up to a 30-day supply of covered prescription drugs when they are dispensed by a participating Express Scripts pharmacy. When you need a prescription filled, just present your drug card along with the prescription and pay the applicable copayment as shown below:

Brand Name Prescriptions	$30
Generic Equivalent Drugs	$20

If you are currently using a maintenance medication, you can take advantage of Express Scripts' Mail Service. It allows you to receive, at your home, up to a 90-day supply of covered drugs for a single copayment as shown below:

Brand Name Prescriptions	$60
Generic Equivalent Drugs	$40

It is important for you to know that whenever an FDA "A-Rated" generic equivalent drug can be substituted for a brand name drug, you will be strongly encouraged to obtain the generic. Specifically, this means that if you choose to receive a brand drug when an A-Rated generic equivalent drug is available, you will be required to pay the difference in cost between the brand and the generic in addition to the applicable copayment. This will occur only if your doctor does not specifically prescribe a brand name drug.

Should you have any questions, please call the Express Scripts Customer Service Department toll free at (800) 451-6245. Your pharmacist may contact the Express Scripts Pharmacy Services Help Desk at (800) 922-1557. You may also visit the Express Scripts website (www.express-scripts.com) to help locate the Express Scripts pharmacy nearest you.

COVERED DRUGS

1. Federal Legend prescription drugs.
2. Drugs requiring a prescription under the applicable state law.
3. Diabetic supplies (except for alcohol wipes and glucose monitors).
4. Insulin syringes.
5. Injectable insulin.
6. Contraceptive devices.

EXCLUDED DRUGS

1. Non-Legend drugs other than insulin.

2. Therapeutic devices or appliances, support garments and other non-medical substances.

3. Drugs intended for use in a physician's office or another setting other than home use.

4. Investigational or experimental drugs; including compounded medications for non-FDA approved use.

5. No compound medication will be considered covered if any of the ingredients in the compound medication are either not approved by the FDA or listed separately as an exclusion under the Plan.

6. Prescriptions which an eligible person is entitled to receive without charge from any workers' compensation laws, or any municipal, state, or federal program.

7. Rogaine.

8. Anorexiants.

9. Impotence drugs.

10. Legend homeopathic products.

11. Prescription medications that have over the counter (OTC) equivalents.

12. Over the counter (OTC) products.

Prior Authorization
In some instances, any individual or class of medications may require prior authorization by Express Scripts to ensure that the following coverage criteria are met:

1. The prescription is for the treatment of a medical condition.

2. There is sufficient evidence to draw conclusions about the effect of the prescription on the medical condition being treated and, on your health, outcome;

3. The expected beneficial effects of the prescription outweigh the expected harmful effects.

4. The prescription represents the most cost-effective method to treat the medical condition.

SPECIALTY MEDICATIONS

Due to the emergence of biotechnology agents to treat certain disease states that are high in costs and require the expertise and oversight by an industry leader in pharmacy benefit management (referred to as "Specialty" drugs), the Trustees approved an Express Scripts program that coordinates the authorization and delivery of these Specialty medications through its subsidiary Accredo Pharmacy. **This part of the overall prescription benefit program applies to Specialty drugs only (primarily self-injectables but also includes some oral and inhaled drugs as well). Normal medications should continue through the Express Scripts retail or mail order programs.** The first Specialty medication should be filled through Express Scripts but after that the Accredo program must be used for that same medication. Once Accredo identifies your having received a Specialty medication through an Express Scripts network pharmacy, they will correspond with you to help you transfer into this new program.

Through Accredo, medication and supplies necessary for administration will be delivered to your home or your doctor's office within 72 hours after receipt of a prescription requiring no additional information from the physician to process the order or within 24 hours prior to the next injection date.

This program provides access to a staff of pharmacists, nurses and patient care coordinators who are specialists in these types of medications and the conditions those medications treat. Also available is educational support or home instruction information. Ancillary supplies such as syringes and needles are provided at no charge.

Following is a current Accredo list of Specialty Drugs (this list is subject to change and from time to time may include drugs that are not covered by the Major Medical Plan). If you happen to identify a medication on this list that you are currently taking you should expect notification from Accredo after your first Specialty medication filled through an Express Scripts network pharmacy. The Accredo phone number is (866) 848-9870 should you or your physician wish to speak directly with an Accredo pharmacist.

You might also wish to supply a copy of this section to your physician if you think you might be affected by this program.

If you have any questions about this program, we urge you to call the Trust Fund Office at (562) 463-5065 or the Express Scripts Customer Service Department at (800) 451-6245.

ACCREDO SPECIALTY DRUG LIST

The Accredo specialty drug list is provided as a guide and is updated periodically based on information from Express Scripts. For precise details related to your specialty drug benefit (through Accredo), please call customer service at (800) 451-6245 or visit the website https://accredo.com/. Please note, this list is subject to change.

BLOOD GLUCOSE MONITORING PROGRAM

Program Description/Goal

The Blood Glucose Monitoring Program encourages members to use a glucose-monitoring device in the management of their diabetes. The program offers a free blood glucose monitoring kit to applicable members. This offer is made available by Lifescan Inc. and Roche Diagnostics. At no time will Express Scripts make individually identifiable patient information related to this program available to any manufacturer.

Scope/Clinical Rationale

The American Diabetes Association recommends people with diabetes monitor their blood sugar to make sure their diabetes is well managed. Checking blood sugar is an important way to see how the body handles food, activity, medications, stress, and illness.

Client Exclusions
This offer is not available to plans or members who are entitled to benefits under Medicare, Medicaid or other state or federal health care programs.

Detail Criteria
For this program, members are selected if they receive medications typically used to manage diabetes (insulin and/or oral antidiabetic prescriptions) and are *either* not currently using blood glucose meter test supplies *or* are using non-prescription blood glucose meter test supplies.

If you or your doctor would like more information about this program, please call Express Scripts directly at (800) 451-6245.

ADVANCED UTILIZATION MANAGEMENT PROGRAM

The Express Scripts Advanced Utilization Management program manages patient drug utilization and drug spend. The program helps guide members to safer, more cost-effective drug choices using clinically based criteria, designed to ensure that each choice reflects the right drug with the right amount for the right patient. The overall program consists of three components:

1. Prior Authorization – Applies evidence-base authorization criteria to ensure that patients use the medication that is clinically appropriate for their condition.

2. Step Therapy – Encourages patients to use clinically effective, proven medications before higher cost medications.

3. Drug Quantity Management – Promotes appropriate dispensing by aligning quantities with FDA-approved dosage guidelines and other medical evidence.

VISION CARE BENEFITS PROVIDED THROUGH VSP FOR MAJOR MEDICAL PLAN PARTICIPANTS

This Vision Care Plan features an extensive network of Doctors to provide professional vision care for persons covered under the Major Medical Plan. This coverage assures the finest quality professional care and eyewear, at a uniform cost.

WHAT ARE THE BENEFITS

Vision Exam
A complete analysis of the eyes and related structures to determine the presence of vision problems, or other abnormalities.

Lenses
The VSP Doctor will order the proper lenses (only if needed). The program provides the finest quality lenses fabricated to exacting standards. The Doctor also verifies the accuracy of the finished lenses.

Frames
VSP offers a wide selection of frames. However, if you select a frame which costs more than the amount allowed, there will be an additional charge.

Contact Lenses
When patients choose contact lenses, VSP will make an allowance toward their cost in lieu of eyeglasses (lenses and frames) for that eligibility period, as outlined under, "HOW OFTEN ARE SERVICES AVAILABLE?"

HOW MUCH DO I PAY?

STEP ONE. When you are ready to obtain vision care services, call your VSP doctor. If you need assistance in locating a VSP doctor, call VSP at (800) 877-7195 or visit www.vsp.com.

STEP TWO. When making an appointment, identify yourself as a VSP member. The VSP doctor will ask for the covered member's identification number (usually the last four digits of your social security number). The VSP doctor will contact VSP to verify your eligibility and plan coverage. The doctor will also obtain authorization for services and eyewear. If you are not eligible, the VSP doctor will notify you.

STEP THREE. At your appointment, the VSP doctor will provide an eye exam and determine if eyewear is necessary. If so, the VSP doctor will coordinate the prescription with a VSP-approved, contract laboratory. The VSP doctor will itemize any non-covered charges, and have you sign a form to document that you received services. VSP will pay the doctor directly for covered services and eyewear. You paid the doctor any applicable copayment(s), and any additional costs resulting from cosmetic options, or non-covered services and materials you have selected. Selecting a participating doctor from VSP's network assures direct payment to the doctor and guarantees quality services and eyewear.

WHAT IF I DON'T USE A VSP DOCTOR?

More than 90% of VSP patients receive services from VSP doctors, although you may select any licensed vision care provider for services. Your reimbursement schedule does not guarantee full payment, nor can VSP guarantee patient satisfaction, when services are obtained from an out-of-network provider.

Follow these steps if you obtain services and/or eyewear from an out-of-network provider:

1. Pay the provider the full amount of the bill and request a copy of the bill that shows the amount of eye exam, lens type and frame.

2. Send a copy of the itemized bill(s) to VSP. The following information **must** also be included in your documentation:

   (a) Member's name and mailing address.

   (b) Member's identification number (usually the last four digits of your Social Security number).

   (c) Member's group name (the O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund).

   (d) Patient's name, relationship to member and date of birth.

Please mail the itemized bill(s) and form to the following address:

VSP
P.O. Box 997105
Sacramento, California 95899-7105

Please note that claims for reimbursement must be filed within six months of the date services were completed.

WHO IS ELIGIBLE?

Available to all members and their dependents covered by a collective bargaining agreement providing VSP vision care, except those who are covered under the Kaiser Foundation Health Plan who have vision care at Kaiser facilities.

HOW OFTEN ARE SERVICES AVAILABLE?

STANDARD EYE EXAM AND GLASSES

Eye Exam:	Once each 12 months*
Lenses:	Once each 24 months*
Frame:	Once each 24 months*

* *From your last date of service*.

LENSES AND FRAME

VSP covers a wide selection of frames, but not all frames will be covered in full. When a patient selects cosmetic options or a frame that exceeds the plan's allowance, these additional charges are administered at VSP's preferred member pricing. Please consult your VSP doctor about lens options which may be cosmetic in nature and may result in additional costs.

CONTACT LENSES

Contact lenses may be provided instead of glasses. An allowance will be provided toward the standard eye exam, contact lens evaluation exam, fitting costs, and materials. Any costs exceeding the allowance are the patient's responsibility.

WHAT ARE THE LIMITATIONS?

OPTIONS
This plan is designed to cover your visual needs rather than cosmetic materials. If you select any of the following, you will be responsible for an additional charge:

1. Blended lenses.
2. Contact lenses (except as noted elsewhere herein).
3. Oversize lenses.
4. Progressive multifocal lenses.
5. Photochromic or tinted lenses other than Pink 1 or 2.
6. Coated or laminated lenses.
7. A frame that exceeds the plan allowance.
8. Certain limitations on low vision care.
9. Cosmetic lenses.
10. Optional cosmetic processes.
11. UV protected lenses.

NOT COVERED
The following professional services or materials are not covered. Discounts may apply to some items.

1. Orthoptics or vision training and any associated supplemental testing.
2. Plano lenses (non-prescription).
3. Two pair of glasses in lieu of bifocals.
4. Lenses and frames furnished under this program which are lost or broken will not be replaced except at the normal intervals when services are otherwise available.
5. Medical or surgical treatment of the eyes.
6. Corrective vision services, treatments, and materials of an experimental nature.

Savings on Other Benefits
VSP doctors offer valuable savings including a 20% discount on non-covered pairs of prescription glasses (lenses and frames). For example, you may wish to purchase a second pair of glasses at your own expense in addition to your already covered first pair of glasses or contact lenses. You can also save 15% off the cost of your contact lens exam when you receive contact lens services from VSP (this discount does not apply to the contact lenses).

LIFE INSURANCE AND AD&D BENEFIT SUMMARY

Your Plan at a Glance: Life and Accidental Death & Dismemberment (AD&D) Summary

Basic Life and AD&D

Basic Life	Basic Life Insurance coverage is provided to you at no cost by O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund in the amount of $12,500.
Basic AD&D	Basic AD&D Insurance coverage is provided to you at no cost by O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund in the amount of $12,500. Basic AD&D pays in the event of your accidental death or dismemberment. The AD&D benefit is paid in addition to your basic life insurance.
Accidental Death & Dismemberment Benefit Schedule	Loss: Percentage payment of the scheduled amount ($12,500) is: Loss of Life: 100% Loss of sight in both eyes: 100% Loss of one hand and sight in one eye: 100% Loss of one foot and sight in one eye: 100% Loss of both hands or both feet: 100% Quadriplegia: 100% Paraplegia: 50% Hemiplegia: 50% Loss of one hand: 50% Loss of one foot: 50% Loss of one eye: 50% Loss of sight of one eye: 50% Loss of speech: 25% Loss of hearing: 25%
Accelerated Death Benefit	Up to 50% of the Basic Life Insurance in force.
Coverage Termination	Coverage terminates at retirement
Eligibility	All Eligible Active Employees of Contributing Employers whose employment is the subject of a Collective Bargaining Agreement by and between the Contributing Employers and the Office and Professional Employees International Union Locals 30 & 537

The following exclusions apply to your Accidental Death & Dismemberment coverage: Suicide or attempted suicide while sane or insane; War or act of war; Disease, bodily or mental infirmity, or infection (except bacterial infection from a visual accidental injury); Intentional self-inflicted injury; Drugs unless prescribed by physician; Driving while intoxicated as defined by the applicable state laws where the loss occurred; Commission of felony, crime or assault; Flight, unless fare paying passenger on commercial flight; engaging in hazardous activities including skydiving, hang gliding, auto racing, mountain climbing, Russian Roulette, autoerotic asphyxiation or bungee jumping.

Life and Accidental Death & Dismemberment coverages are underwritten by Unimerica Insurance Company, 6300 Olson Memorial Hwy, Golden Valley, MN 55427. This is a summary of benefits and does not include all plan provisions and exclusions. Late applicants are subject to Evidence of Insurability.

This is an overview of your benefits. The contract will govern actual benefits. The Company reserves the right to make future changes.

MEDICAL AND DENTAL EXPENSE BENEFITS COORDINATION

Medical and Dental Expense Benefits are subject to the following Coordination of Benefits provision.

"Coordination" means that if the covered person is entitled to benefits under any plan (Plan defined below) which will pay part or all of the expenses incurred for services and supplies for treatment of an illness or injury, the amount of benefits payable by this Plan and any other Plans will be coordinated so that the aggregate amount paid will not exceed the amount that would be paid if this Plan were the primary payer. The O.P.E.I.U. Locals 30 & 537 Health and Welfare Fund payment will not exceed the amount which would have been paid if there were no other Plan involved.

The term "Plan" includes the benefits payable under this Plan and any other plan providing benefits or services for or by reason of medical or dental care treatment, which benefits or services are provided by: (a) group, blanket or franchise insurance coverage, (b) service plan contracts, group practice, individual practice and other prepayment coverage, (c) any coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit organization plans, and (d) any coverage under governmental programs, and any coverage required or provided by any statute.

If a person covered under this Plan is also covered under another Plan or Plans and, as a result, has two or more coverages, and the other Plan has a similar duplication of coverage provision, rules set out in this Section establish the Plan that will pay benefits first and the Plan that will pay the benefits not paid by the first Plan.

SPECIFIC CONDITIONS AND HOW THEY ARE APPLIED IN PAYMENT OF CLAIMS FOLLOW

Active/Retired or Laid-Off Employee
The Plan covering a person as an employee who is neither laid-off nor retired (or as that person's dependent) pays benefits first. The Plan covering that person as a laid-off or retired employee (or as that person's dependent) pays benefits second.

Employee/Dependent
The Plan covering the person as an employee pays benefits first. The Plan covering the person as a dependent pays benefits second.

Dependent Children of Parents not Separated or Divorced
The Plan covering the parent whose birthday falls earlier in the year pays first. The Plan covering the parent whose birthday falls later in the year pays second. If both parents have the same birthday, the Plan which covered the parent longer pays first. The Plan which covered the other parent for a shorter time pays second. The year of birth is not relevant in applying this rule.

However, if one coordinating Plan uses a birthday rule and the other uses a male/female rule, both Plans will follow the male/female rule.

Dependent Children of Separated or Divorced Parents
When parents are separated or divorced, neither the male/female nor the birthday rules apply. Instead:

1. The Plan of the parent with custody pays first.
2. The Plan of the spouse of the parent with custody (the stepparent) pays next; and
3. The Plan of the parent without custody pays last.

However, if the divorce decree places the fiscal responsibility for the child's health care expense on one of the parents, then the Plan covering that parent pays benefits first.

Longer/Shorter Length of Coverage
If none of the above rules determines the order of benefits, the Plan covering a person longer pays first. The Plan covering that person for the shorter time pays second.

EXCEPTION
The Plan which covers as an active employee or as a dependent of an active employee will pay before the Plan which covers such person as a retired employee or as a dependent of a retired employee, regardless of the length of time each Plan has covered such person.

EXCEPTIONS FOR PERSONS COVERED BY MEDICARE

Coordination with Medicare
When you or your dependent are eligible for both Medicare benefits and benefits under this Plan, this Fund will coordinate benefits with Medicare.

Employee
For Employees and dependents eligible for Medical Benefits, this Fund will be, in most cases, the primary payor with Medicare paying on a secondary basis. (Refer to definition of Dependent on page 21).

COORDINATION WITH PRE-PAID PLANS (MEDICAL AND DENTAL)
If your spouse is covered under another Fund or form of health insurance as an employee under a pre-paid plan and as a dependent under the O.P.E.I.U. Locals 30 & 537 Health and Welfare Trust Fund, no benefits will be payable under this Fund if your spouse does not receive treatment from the pre-paid plan. If your spouse seeks or receives treatment from the pre-paid plan, the secondary coverage under this Fund will coordinate benefits in accordance with the above indicated provisions.

If you are covered as an Employee under this Fund and as a dependent under a pre-paid plan sponsored by your spouse's employer, you may receive treatment from either your own provider or privately selected hospital or from the pre-paid provider or hospitals. If you receive treatment through the pre-paid plan, your primary coverage under this Fund will pay its normal benefits for any expenses that you are legally obligated to pay.

Obtaining Information
Information necessary to the administration of this Coordination of Benefits Provision will be required of the employee at the time a claim is submitted.

The Fund shall have the right to request an Employee and/or an Employee's dependent spouse to sign a consent authorizing the Fund to release to, or obtain from, another Plan any information necessary to the implementation of its coordination of benefits provision. If requested, no applicable claims shall be processed until the employee or dependent spouse gives such consent.

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

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

Assignment and Reimbursement to Fund of Benefit Payments for Accident or Injury
If a Participant or one claiming through him, e.g., heirs, beneficiaries, personal representatives, or estate, etc., may have payments inure to his benefit, from whatever source and whether completed or to occur in the future, in whole or in part for injury or illness for which benefits are otherwise provided by the Fund, such benefits shall be limited to a maximum of $2,500 and any benefits exceeding $2,500 are excluded from coverage by the Plan.

Audit of Doctor and Hospital Bills
For your protection, and to ensure that proper payment is made, the Fund may require doctors and hospitals to submit to an audit of billings made for care provided. The Fund may require employees and dependents to authorize such audits, and if requested by the Fund, the granting or permission to audit doctor and hospital bills shall be a condition precedent to payment of such bills.

GENERAL PROVISIONS

No Assignment of Benefits
Benefits paid hereunder shall not be subject in any manner to anticipation, alienation, sale, transfer, assignment, pledge, encumbrance, or charge by any person; however, any eligible Employee may direct that benefits due him/her be paid to an institution in which he/she or his/her eligible Dependent is hospitalized or to any other provider of medical or dental care services or supplies in consideration for medical, hospital or dental care services rendered or to be rendered.

Disclaimer
The fee-for-service medical benefits described in this booklet are not insured by any contract of insurance and there is no liability on the Board of Trustees or any individual or entity to provide payment over and beyond the amounts in the Fund collected and available for such purposes.

Amendment and Termination
In order that the Fund may conduct its obligation to maintain within the limits of its resources, a program dedicated to providing the maximum possible benefits for all Participants, the Board of Trustees expressly reserves the right, in its sole discretion at any time and from time to time:

1. to terminate or amend the amount or eligibility conditions with respect to any benefits even though such termination or amendment affects claims which have already accrued.

2. to terminate the Plan even though such termination affects claims which have already accrued.

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

4. to amend or rescind any other provisions of the Plan.

STATEMENT OF ERISA RIGHTS

As a participant in the O.P.E.I.U. Locals 30 & 537 Health & Welfare Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the plan administrator's office and at other specified locations, such as worksites and union halls, all plan documents, 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.

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

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

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 other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a benefit or exercising your rights under ERISA.

Enforce Your Rights
If your claim for a welfare benefit is denied in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a federal court. In such a case, the court may require the plan administrator to provide the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator. If you have a claim for benefits which is denied or ignored, in whole or in part, and you have followed and exhausted the Plan's Claims and Appeals Procedures starting on page 8, you may file suit in state or federal court. In addition, if you disagree with the plan's decision or lack thereof concerning the qualified status of a domestic relations order or a medical child support order, and you have requested the Board of Trustees to review your situation and you are still dissatisfied with their decision, you may file suit in federal court. If it should happen that plan fiduciaries misuse the plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have

sued to pay these costs and legal fees. If you lose, the court may require you to pay these costs and legal fees; for example, if the court finds your claim is frivolous.

Assistance With Your Questions

If you have any questions about your plan, you should contact the plan administrator. 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, listed in your telephone directory 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. For more information about your rights and responsibilities under ERISA visit www.dol.gov/ebsa. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration at 1-866-444-3272.

NOTES