SAN MATEO ELECTRICALWORKERS HEALTH CARE BENEFIT PLAN

Restated Summary Plan Description and Plan Document

(For Inside Wire Members of IBEW LOCAL 617)
Including Apprentices, Retirees and Spouses and Dependents

Benefits in Effect as of
JANUARY 2023

Keep this Summary Plan Description and Plan Document For Future Reference

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Dear Participant & Dependent:

This 2023 Restated booklet known as a Summary Plan Description ("SPD") is both the Summary and the actual Plan document for the San Mateo Electrical Workers Health Care Plan ("Plan") as required by the Employee Retirement Income Security Act of 1974, as amended ("ERISA"). This booklet (sometimes called the "Plan Rules") contains an explanation of the eligibility provisions and benefits for both Active (including apprentices) and Retired Participants and their Dependents (as defined by the Plan). Your eligibility for benefits is also dependent upon your employer making timely contributions to the Trust Fund on your behalf and any eligible self-payments you may be able to make for continued coverage. Additional information on the Plan, including a variety of forms, can be obtained from the Trust Fund's website, which is *www.ibew617benefits.com*. We urge you to familiarize yourself with the provisions and benefit structure of your Plan. Please direct any questions you have to the Plan Office at (408) 288-4400.

From time to time the Plan office may mail you updated material to inform you and your Dependents of any changes in benefits, known as "Summary of Material Modification" (SMM). It is important that you keep all mailings received with this booklet.

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

Open Enrollment is held each year, generally from April 15th through May 15th, you may elect to change your benefit plan options selection by completing a new enrollment card through the Plan Office. If the open enrollment date changes you will be notified. Your change, which must be received by the Plan Office by May 15th will be effective June 1st of that year. Insurance Provider benefit booklets (also known as the Evidence of Coverage) are available at the Plan Office or at the Local Union Office.

The Board of Trustees has authorized the Plan Office to respond in writing to your written questions. As a courtesy to you, the Plan Office may respond informally to oral questions; however, oral information and answers are not binding upon the Board of Trustees or the Plan and cannot be relied on in any dispute concerning your benefits. If you have an important question about your benefits, you should write to the Plan Office at:

United Administrative Services
P.O. Box 5057
San Jose, CA 95150-5057
Phone: (408) 288-4400

Plan rules and benefits may change from time to time. Your benefits under the Plan are NOT vested. The Board of Trustees may reduce, eliminate or change any benefit provided under the Plan or any insurance policy, HMO or other entity at any time. The Plan will provide you with a summary of important material changes. You may also receive replacement pages for this booklet. Please be sure to read all Plan communications and keep your booklet up to date by adding replacement pages as soon as you receive them.

Sincerely,
The Board of Trustees

FUTURE PLAN AMENDMENTS

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

LIMITATION UPON RELIANCE ON BOOKLET AND STATEMENTS

This booklet provides a brief, general summary of the Plan rules and is also the Plan document. You should review the Plan to fully determine your rights. **You are not entitled to rely upon oral statements of Employees of the Plan Office, a Trustee, an Employer, any Union representative, or any other person or entity.**

As a courtesy to you, the Plan Office may respond orally to questions; however, oral information and answers are not binding upon the Plan and cannot be relied upon in any dispute concerning your benefits. If you would like an interpretation of the Plan, you should address your request in writing to the Board of Trustees at the Plan Office. To make their decision, the Trustees must be provided with full and accurate information concerning your situation. You should also ensure that you provide accurate facts in all forms and documents submitted to ensure you are not held liable for coverage of ineligible Dependents and/or claims.

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

NO GUARANTEE OF PROVIDER

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

NO VESTED RIGHTS

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

ALERT: ONE YEAR PERIOD TO FILE A LAWSUIT

If an appeal has been denied or there has been a different form of adverse action taken, such person (Participant, Beneficiary or any other person or entity) has one year from the date of such denied appeal or adverse action to file a lawsuit against the Plan, an individual Trustee, the Board of Trustees and/or any other person or entity involved with the denied appeal or adverse action. If the person fails to do so, no lawsuit is permitted. This one-year limitation period covers any and all claims for benefits referenced in this Plan and is intended to supersede any language in this Plan document to the contrary.

Board of Trustees

Labor Trustees	Management Trustees
Scott Wein, Co-Chair *IBEW Local Union No. 617*	**William Kuhr, Chair** *NECA, San Mateo Chapter*
David Mauro *IBEW Local Union No. 617*	**David Chad** *Decker Electric*
Dan Pasini *IBEW Local Union No. 617*	**Brian Iwashita** *Palmer Electric*
Abe Talakai *IBEW Local Union No. 617*	**Tim Lynch** *Lynch Electric*

Plan Professionals

Plan Administrators	Benefit Consultant
United Administrative Services Sandy Stephenson, Fund Manager *6800 Santa Teresa Blvd., Suite 100* *San Jose, CA 95119* *https://ibew617benefits.com*	**Innovative Cost Management Services, Inc.** Mike Finnerty & Brandon Hayden *95 S. Market Street, Suite 600* *San Jose, CA 95113*
Plan Auditors	**Pharmacy Benefit Consultant**
Ineich & Company LLP Michael Savasta *950 Tower Lane, Suite 780* *Foster City, CA 94404*	**Health LinX** Alan Kellog, Allie Valdez, Story Bell & David Westengard 833 East Pioneer Road, Unit 103 Draper, Utah 84020
Attorney	**Investment Consultant**
Neyhart, Anderson, Flynn & Grosboll APC Lois H. Chang & Richard K. Grosboll *369 Pine Street, Suite 800* *San Francisco, CA 94104*	**Graystone Consulting** Craig Dobbs *800 East 96th Street, Suite 400* *Indianapolis, IN 46240* **Morgan Stanley** Matt Carson *500 108th Ave., NE, Suite 1900* *Bellevue, WA 98004*
Payroll Auditor	**HRA Administrator**
Compliance Audit Services John Martin *2249 Derry Way* *South San Francisco, CA 94080*	**NAVIA Benefit Solutions** *https://www.naviabenefits.com* *P.O. Box 53250* *Bellevue, WA 98015*
Wellness Program	
Bay Sport *14830 Los Gatos Blvd. National Ave #101* *Los Gatos, CA 95032* *https://baysport.com*	

Highlights of Important Plan Changes

This summary highlights important Plan changes since the last time this booklet was provided to you.

- Plan amended to cover **medically necessary transgender services**, continue coverage for **widows/widowers** (age 65 or older) of deceased active participants, and to offer **Medicare supplemental plan to out-of-state retirees** at the same rate as in-state retirees.
- Plan amended to cover **Nutritional Counseling services** at certain visit limits & cost-sharing.
- Although a Grandfathered plan and not required to, Plan amended to voluntarily cover in-network **Affordable Care Act recommended preventive services** (at 100%, no charge).
- Plan amended to add **voluntary wellness program through Baysport.**
  Plan amended to **clarify eligibility rules for Pre-Apprentices and Regular apprentices** and are not entitled to separate hour bank.
- Plan amended to increase **reserve hour bank maximum** from "10-months" to "12-months."
- Plan amended to clarify the **definition of eligible "domestic partners**" to comply with California legislation removing requirement that opposite-sex couples have to be over age 62 to be able to enter into a domestic partnership.
- **COVID 19.** Plan amended during public health emergency period and beginning of the pandemic to cover COVID-1 testing, services and items (including over-the counter COVID-19 testing kits), treatment, vaccination (pursuant to federal mandate), temporary extensions to file COBRA and certain claims during the public emergency period, and temporary subsidized continued coverage for those who lost coverage due to COVID-19 and depleted their hours bank reserves (NOTE: This temporary subsidized provision has since expired).
- **Short Term Disability** Plan rules amended to increase monthly benefit from $650 to "$1,000 per month", clarify eligibility is on "12-month per disability basis" (not 12 month per life time basis) but still require participants to have been covered under the Plan at least 12 out of 15 months.
- **Orthotic Devices.** Orthotic devices amended to replace "every 5 years" with "once every twelve months" for medically necessary orthotic devices.
- **Mental Health/Substance Abuse Benefits.** Plan amended to offer behavioral health program through Optum (instead of Anthem) for self-funded plan and to offer the Employee Assistance Program primarily through Optum United Health for all eligible Kaiser and self-funded participants (and their dependents).
- **Hearing Aid.** Hearing aid benefit amended to increase to $2,000 per 12-month period for each ear excluding apprentices.
- **Vision.** Vision Benefits amended to allow for $25 prescription safety glass co-pay (one pair per year).
- **Disabled Adult Dependent Children Coverage.** Plan amended to allow for continued coverage for Disabled Adult Dependent Children beyond the Affordable Care Act required age limit of 26 provided certain eligibility conditions are met.
- **Federal Mandates.** Plan amended to comply with New Federal laws like the Consolidated Appropriations Act and No Surprises Act.
- **Venue Limit & Class Action Waiver.** Plan amended to allow for choice of venue limitation and class action waiver to minimize potential legal fees and costs for claims disputes involving litigation.

I. GENERAL – RESTATED PLAN

A. ESTABLISHMENT OF PLAN.

1. **Restatement of Plan:** The Board of Trustees restates the **San Mateo Electrical Workers Health Care Benefits Plan** as of January 1, 2023. The Plan's medical (including hospital, mental health and substance abuse) benefits are offered to Actives through: (1) a self-funded portion of the Plan, using a network of providers and Joint Administrative Services Agreement with Anthem Blue Cross of California (hereafter sometimes referred to as "Anthem Blue Cross") and (2) also through a Health Maintenance Organization, which is Kaiser Permanente (HMO) (hereafter "Kaiser"). Retiree medical benefits are offered through the following: (1) Kaiser Permanente Senior Advantage (HMO), (2) Blue Shield of CA Medicare Supplement Plan, (3) Kaiser Permanente HMO Plan for Early Retirees (non-Medicare), (4) Anthem Blue Cross PPO Plan for Early Retirees (non-Medicare) and (5) Hartford Medicare Supplement Plan (out-of-state retirees). If you enroll in the Kaiser HMO option, a separate Evidence of Coverage ("EOC") prepared by the HMO will be provided to you. Other benefits are provided as listed in section 6 on the next page of this booklet. The provisions of this Plan are effective as of January 1, 2023, although certain provisions may have different effective dates as noted.

The Plan is intended to be maintained for the exclusive benefit of Participants and their eligible Dependents. It is also intended that this Plan Document shall conform to the requirements of the Employee Retirement Income Security Act of 1974, as amended (ERISA), as that Act applies to multiemployer health and welfare employee benefit plans such as the Plan.

2. **Election of Health Maintenance Organization (HMO) Benefit Option:** The Board of Trustees provides the option to elect enrollment by the eligible Participant and his or her eligible Dependents in one or more Health Maintenance Organizations (HMO). Currently, the Plan offers an insured HMO (through Kaiser Permanente) and self-funded PPO benefits through Anthem Blue Cross.

An HMO uses a group of doctors and other health care professionals who emphasize preventive care and early intervention. HMO services are prepaid and a designated premium covers service. You share some costs, however, by paying a fee called a co-payment for some services and products. Benefits provided pursuant to the group insurance or HMO contract are paid by the applicable insurer or HMO. The Plan has no financial responsibility to pay any participant or dependent any insured benefits. Instead, the Insurer or HMO is solely responsible for paying such benefits.

To be eligible to enroll in an HMO, you must live within the HMO's service area. Moreover, services may not be covered unless preauthorized by your Primary Care Physician (PCP). For medical services to be covered you must follow the HMO procedures and you must use an HMO network provider. You are required to include a residence address (rather than a P.O. Box) when you complete your Enrollment Form. If you move out of the geographic area of the HMO, you may be required to change your coverage under the Plan. You and your family members are required to have the same coverage selection (for example, one family member cannot select Kaiser and the other Blue Cross). The times and the geographic areas in which such enrollment may be open to Plan Participants will be determined by mutual agreement between the Board of Trustees and the HMO.

3. **Self-Funded Preferred Provider Organization (PPO) Benefit Option:** Currently, the Plan also offers PPO benefits through the Anthem Blue Cross Plan. The Self-funded PPO benefits are provided only to the extent that the plan has adequate resources to pay for such benefits. The PPO network providers contracted by Anthem Blue Cross have agreed to accept negotiated rates for payment and you should not be billed for

amounts beyond your applicable deductible (if any) and coinsurance payment. If you choose to receive your care from a non-PPO provider, then you will be responsible not only for, if any, deductible and your portion of the coinsurance, but you may also be billed for the difference between what the plan pays and the actual charge made by the Non-PPO Provider. There are some exceptions for certain services or items covered under the No Surprise Act. The self-funded PPO option allows you to receive care from any of the doctors, other health care professionals, and hospitals within the plan's network, as well as outside of the network for covered services. Unlike the HMO option, the advantage of choosing the PPO option includes the flexibility of seeking care with an out-of-network provider (subject to higher deductible and/or coinsurance) and the ability to visit any specialist without obtaining a referral from your primary physician. If you do not have a copy of the Anthem Blue Cross PPO provider list, you may obtain a copy at no charge from the Plan Office or contact Anthem Blue Cross to assist you in choosing a doctor for you and your family.

To illustrate how the PPO option works, let's say you (Active) pay a co-payment (e.g., $15) at the time of your specialist office visit at a PPO Network provider. There is no deductible. However, if let's say you (Active) go to a Non-PPO Network provider for a specialist office visit then you also pay a co-payment (e.g., $15) but you will also have a yearly deductible (e.g., $250 individual or $500 family) to meet before the Plan starts paying your medical costs. After that, some services you receive may be 100% covered or you may have to pay a coinsurance (e.g., 10% if in-network provider or 40% of out-of-network provider) which is your share of costs calculated as a percentage of the allowed amount for your covered service. Please refer to your copy of the Summary of Benefits and Coverage ("SBC") for a more recent detail of the applicable cost-sharing amounts that may apply to you and/or your family members. For a copy, please contact the Trust Fund Office. The SBCs are also mailed to you annually.

4. **Incorporation of HMO as Part of Plan:** At any time or times that the Board of Trustees enters into a new or different contract and/or renewal contract with an HMO, such contract(s) is incorporated in this Plan effective as of the date of such contract, provided same has been executed by the Board of Trustees or a duly authorized representative of the Board of Trustees.

5. **Consequences of Election of HMO Plan by Participant:**

a. Benefits Not Part of HMO. Benefits payable to an Employee, Participant and/or eligible Dependent(s) who has elected enrollment in an HMO shall be determined solely in accordance with the contract between the Trustees and the HMO except for Life Insurance and Accidental Death and Dismemberment (through an Insurance Company) (Actives only).

b. HMO Rules Apply. All rules and/or regulations set forth herein regarding claims review and/or appeals, shall be governed by the rules and regulations of the HMO without regard to similar rules and regulations that may be otherwise set forth in this Plan.

6. **Additional Benefits:** The Plan provides the following types of additional benefits subject to certain eligibility provisions and exclusions to eligible Participants and their Dependent(s):

a. **Life Insurance and Death Benefit** (through MetLife Life Insurance Company) (*Actives only);*
b. **Dental Care** (through Delta Dental) (*Actives, Retirees, Apprentices & Dependents*);
c. **Orthodontic** (through Delta Dental) (*Actives, Retirees, Apprentices & Dependents*);
d. **Vision Care** (through VSP) (*Actives, Retirees, Apprentices & Dependents*) (for PPO only)
e. **Hearing Aid Benefits** (*for non-apprentice Actives and Retirees*);
f. **Residential Treatment Benefit for Chemical Dependency** (through HMO or Self-Funded); and

g. **Pharmacy Benefits** (Self-funded through Sav-RX) (*Actives, Retirees, Apprentices & Dependents*).

HMO and Carrier Rules Apply. All rules and/or regulations set forth herein regarding claims review and/or appeals, shall be governed by the rules and regulations of the HMO and Carrier without regard to similar rules and regulations that may be otherwise set forth in this Plan.

B. PLAN MAY BE CHANGED.

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

1. Terminate or amend either the amount or condition with respect to any benefit, even though such termination or amendment affects claims which have already accrued; and
2. Alter or postpone the method of payment of any benefit; and
3. Amend, terminate or rescind any provision of the Plan; and
4. Merge the Plan with other plans, including the transfer of assets; and
5. Terminate any HMO or insurance company; and
6. Restrict coverage to those living only in certain geographic areas.

The authority to make any changes to the Plan rests solely with the Board of Trustees.

C. PLAN AND OPERATION.

1. Board of Trustees Responsibilities: The Plan is administered by a Board of Trustees comprised of up to ten Trustees. One-half of the Trustees, called "Employer Trustees," are selected by the Employer Associations signatory to Collective Bargaining Agreements with IBEW Local 617 and one-half of the Trustees, called "Union Trustees," are selected IBEW Local 617. The current Trustees are listed on page vi of this booklet.

The Trustees have many powers and functions including investing the Plan's assets, interpreting Plan provisions, amending the Plan, answering policy questions, and contracting with advisors and consultants, such as an auditor, legal counsel, and investment manager.

Only the Board of Trustees and its authorized representatives are authorized to interpret the Plan's benefits described in this booklet. No one else can interpret this Plan or act as an agent for the Board of Trustees -- this includes Employers, Employer Associations, the Union and their representatives. The Board of Trustees (and persons or entities appointed or so designated by the Board of Trustees) has the full discretionary authority to determine eligibility for benefits and to construe the terms of the Plan (and other documents pertaining to the Plan and Trust) and any rules adopted by the Board of Trustees.

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

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

interpretation of the provisions of this Plan. Nonetheless, claims and appeals for matters relating to an HMO are subject to that HMO's rules and procedures.

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

4. Employer Contributions: Employer contributions are made to the Plan pursuant to the terms of Collective Bargaining Agreements with IBEW Local 617. Contribution rates for each hour of your Covered Employment are set, from time to time, by the parties to the Collective Bargaining Agreements. Your Employer is required to contribute only for such hours of work that are required by the Collective Bargaining Agreement. Such amounts may change at any time if agreed to by the bargaining parties.

Your Employer is required to make monthly contributions for your Covered Employment and mail such payments to the bank depository by the **15th** day of the month following the month in which your work was performed. For example: January hours generate employer contributions paid in February which are posted on the Plan's books when received but are not credited to Participants until on or about March 1st. Each monthly payment made by your Employer is accompanied by a transmittal form that contains the names, Social Security numbers, and hours of work performed by each Covered Employee together with a payment to the Plan. The Employer Contributions to the Plan are not subject to withholding for Federal Insurance Contributions Act (FICA), Federal Unemployment Tax (FUTA), or state or federal taxes.

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

IMPORTANT NOTICE:

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

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

5. Loss of Eligibility if no Contributions: You may lose eligibility with the Plan if Employer Contributions are not timely received by the due date for Employer contributions by the Plan Office.

6. Availability of Fund Resources: Benefits provided through the Plan Office can be paid only to the extent that the Plan has adequate resources for such payments. No Contributing Employer has any liability, directly or indirectly, to provide the benefits established hereunder, beyond the obligation to make contributions as provided in the Collective Bargaining Agreement. In the event that at any time the Plan does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any Contributing Employer to make benefit payments or contributions (other than the contributions for which the Contributing Employer may be obligated by the Collective Bargaining Agreement) in order to provide for the benefits established hereunder. There shall be no liability upon the Board of Trustees, individually or collectively, or upon any Employer, the Union, Signatory Associations or other person

or entity to provide benefits established hereunder if the Plan does not have sufficient assets to make such benefit payments.

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

8. Special Exclusion for Fraud/Reimbursement or Offset for Overpayment: No benefits will be paid for fraudulent claims of services or supplies made by a Participant, eligible Dependent, or any other person. If a fraudulent claim has been paid on behalf of any person, both the Participant and any person on whose behalf a fraudulent claim was submitted will be liable to the Plan for repayment. This includes for any other reasons (including, but not limited to enrolling an ineligible dependent under the Plan, failing to notify the Plan that a previously eligible dependent no longer qualifies as a dependent, or failure to timely enroll in Medicare). The Participant and person on whose behalf a fraudulent claim was submitted will also be responsible for any attorney's fees and costs incurred by the Plan as a result of the fraudulent acts.

If a Participant or any eligible Dependent of the Participant has any outstanding liability due to fraudulently paid claims, neither the Participant nor any eligible Dependents may assign any rights to benefits to a provider of service until all fraudulently paid benefits have been repaid in full. If fraudulently paid benefits are not repaid in full, any purported assignment of benefits by a Participant or eligible Dependent may be disregarded by the Plan. However, if any payment of benefits is made by the Plan under a purported assignment, this would not be a waiver of the right of the Plan to refuse to acknowledge other purported assignments.
If any fraudulent claims have not been repaid when a Participant or eligible Dependent incurs covered charges, the Participant or eligible Dependent shall pay all charges directly and file a claim for credit in lieu of benefits, until the entire amount of the fraudulent claims have been credited. The Plan may offset any amounts owed against any benefits that may be payable under the Plan for a Participant and/or his Dependents

In addition, any Participant or eligible Dependent who owes money to the Plan may be required to sign a written agreement before a notary agreeing to have any owed amounts deducted, offset, or paid from any death benefit, benefits payable from a life insurance company with which the Plan has a contract, or payment from any distribution from the Retirement Plan.

9. Plan Year: The Plan Year commences **June 1st** of each year and ends on **May 31st** of the following year. This is a Non-Calendar Year Plan.

10. Grandfathered Plan: The Board of Trustees believes this Plan (both the self-funded and HMO medical option) is a "**Grandfathered health plan**" under the federal law known as the Patient Protection and Affordable Care Act ("ACA"). As permitted by the ACA, a Grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a Grandfathered health plan means that the Plan is not required to include certain consumer protections of the Act that apply to other plans, for example, requiring the provision of preventive health services without any cost sharing. However, Grandfathered health plans must comply with certain other consumer protections in the ACA, such as the elimination of annual and lifetime dollar limits on the Plan's essential health benefits. But annual and lifetime dollar limits are permitted on Non-Essential Health Benefits.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the Fund Manager at the number listed on page v. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor (DOL) at 1–866–444–3272 or *www.dol.gov/ebsa/healthreform.* This website has a

table summarizing which protections do and do not apply to grandfathered health plans. Implementation of the Act's provisions began with the July 1, 2011 Plan Year.

D. YOUR RESPONSIBILITIES.

1. Your Mailing Address: It is your responsibility to keep the Plan Office advised of changes to your address so that you may continue to receive notices of important Plan changes that may affect your coverage or continue to receive Plan information. Changes must be made in writing by completing the appropriate Enrollment Form or Change of Address Form, both of which are available on the Plan's web page for the Plan at https://www.ibew617benefits.com. Please note: neither Kaiser nor Blue Cross will accept a PO Box address as a mailing address or place of residence. All Plan Participants must provide a street address to enroll in either health plan.

2. Enrollment Form: Full completion and return of the Enrollment Form is mandatory for all Plan Participants for enrollment, changes and upon request by the Plan Office. You are required to complete a new Enrollment Form and submit to the Plan required proof when you have a change in life circumstances (such as a marriage, separation, divorce, birth of child, Dependent status changes, Medicare eligibility or QMCSO). In addition, Blue Cross will accept a PO Box address as a mailing address or place of residence and Kaiser will not. All Plan Participants must provide a street address to enroll in either Health Plan. Generally, any changes will be effective the first day of the following month after your updated Enrollment Form is received.

3. Change in Dependent Status: Keep your enrollment form updated by adding a new Spouse or Child with any required proof, such as a marriage or Domestic Partner registration certificate, birth certificate or legal adoption papers. You must also notify the Plan Office if a Dependent ceases to quality as a Dependent, for example, due to divorce, death or the attainment of age 26.

4. Beneficiary Form: You should complete a Beneficiary Form at the time of initial enrollment. If you decide to change your Beneficiary, you must complete a new Beneficiary Form.

5. Protected Health Information (PHI): There are Privacy Rules to protect you based on the federal legislation known as the Health Insurance Portability Accountability Act of 1996 ("HIPAA"). If you wish to authorize someone other than yourself to access information from the Plan Office on your behalf, you must complete the Protected Health Information Authorization Form (available at the Plan Office) and return it to the Plan Office. The Plan's Notice of Privacy Practices is attached as Appendix 1.

6. Identification (ID) Cards: ID cards provide information but are not a guarantee of eligibility or benefits. Eligibility and benefits are verified on a month-to-month basis. Depending on the Health Plan selection elected on your Enrollment Form, you will be sent either a Kaiser ID card or Anthem Blue Cross ID card to access your Medical and Prescription Drug benefits. The ID card issued by the Plan Office covers Dental, Hearing Aid, Vision and Orthodontic (Active only) Benefits. When you submit claims or correspondence to the Plan Office, you should include the last four digits of the Plan Participant's Social Security number. Please note: Vision claims should be submitted to Vision Service Plan (VSP).

II. ELIGIBILITY RULES

A. INITIAL ELIGIBILITY – Active Participant: Active Employees performing work covered by the Collective Bargaining Agreement between IBEW Local 617 and the San Mateo Chapter, NECA, or individual

Employers who have Collective Bargaining Agreements with IBEW Local 617, and which are required to make Employer contributions to this Health and Welfare Fund, are eligible for benefits under the conditions authorized by the Board of Trustees as set forth in this document.

(a) **Non-Bargaining Unit Employees.** Non-bargaining unit Employees, such as Employees of IBEW Local 617 and other Employers approved by the Board of Trustees, are also eligible to participate in this Plan pursuant to eligibility rules and applicable Subscription Agreements.

(b) **Bargaining Unit Employees.** Each bargaining unit Employee performing bargaining unit work becomes eligible for coverage under this Plan on the first day of the second month after the month in which such person has accumulated to his or her credit, a minimum of 600 hours of Covered Employment with Participating Employers for which Employer contributions are actually received.

EXAMPLE: You work in January, February, and March for a total of 600 hours. April is the lag month. Your coverage would begin May 1st.

Your eligibility for benefits depends on the continued and timely payment of Employer contributions on your behalf. In accordance with Plan rules, if your Employer fails to make a contribution when it is due, your eligibility may terminate (depending on the available hours in your Reserve Hour Bank). Eligibility for prior periods may be reinstated when your Employer makes the required contribution on your behalf.
Please remember that the hours you work in any given month determine your eligibility in the second calendar month following your hours worked. In addition, Employers may not always report on a full calendar month due to their specific payroll cut off. Thus, hours reported are based on ONLY those hours reported by your Employer and not necessarily all hours worked in a given calendar month. **The number of hours required to maintain eligibility each month is 120 hours but, could increase in the future, at the discretion of the Board of Trustees.**

SPECIAL RETURN TO WORK RULE AFTER TAKING DISTRIBUTION FROM THE SAN MATEO ELECTRICAL CONSTRUCTION INDUSTRY RETIREMENT PLAN
(Only 40 hours a Month of Hours of Covered employment Credited for Retiree Eligibility)

If you retire and take a partial or full distribution from your Individual Account balance with the San Mateo Electrical Construction Industry Retirement Plan, and then you return to work in Covered Employment, you will still be considered a retiree, requiring self-payment amounts for coverage (unless you have hours in your hour bank or you elect to pay COBRA). **But, if you return to Covered Employment, only a maximum of 40 hours a month of the Employer contributions being made on your behalf will be credited for your retiree health and welfare coverage under the Plan**. By way of example, the current employer contribution rate of $13.67 would be multiplied by 40 hours, which equals $546.80. If you have no additional hours in your hour bank, you will then have to pay the difference, if any, in the Retiree Self-Pay rate between the $546.80 rate and the cost of the monthly premium for the Plan's coverage that you have (which varies, depending upon whether you are enrolled in Kaiser, PPO or the Blue Shield Medical Plan), whether you have a spouse, your spouse's age, and other factors). You may refer to the Retiree Rate Sheet available from United Administrative Services for the different Retiree contribution rates. (The 40-hour maximum does not apply to the additional $3.50 being contributed to your Health Reimbursement Account on your behalf for each hour of Covered Employment. Please note the monthly dollar value could increase.)

B. APPRENTICESHIP ELIGIBILITY RULES:

A. REGULAR APPRENTICES. A Regular Apprentice becomes eligible for coverage under this Plan after the Apprenticeship Program notifies the Trust Fund office that he or she has accumulated a minimum of 300 hours of Covered Employment with Participating Employers (known as "Covered Employment"). To illustrate, if an apprentice accumulates 300 hours in March and the

Trust Fund Office is notified in April, coverage will become effective May 1st). For continuing coverage, the Apprentice (including pre-apprentices that have become indentured apprentices) remains eligible for this coverage as long as he or she remains in the Apprenticeship Program whether working or not. Apprentices are not entitled to a separate hour bank.

B. PRE-APPRENTICES. Pre-apprentices become eligible for coverage under this Plan after the Apprenticeship Program notifies the Trust Fund office that he or she has accumulated a minimum of 300 hours of Covered Employment with Participating Employers (known as "Covered Employment"). For continuing coverage, the Pre-Apprentice remains eligible for coverage so long as the Trust Fund office is notified that the Pre-Apprentice remains in the Pre-Apprenticeship Program. Once a Pre-Apprentice becomes an indentured apprentice their continued coverage is the same as a Regular Apprentice (see the rules above). Pre-apprentices are not entitled to a separate hour bank.

C. RESERVE BANK ACCOUNTS.

1. Reserve Account (Hour Bank) (120 Hours a Month).

A separate reserve account, also known as an hour bank, will be maintained for each Covered Employee showing an accumulation of hours worked for Contributing Employers. Once an Employee is eligible to participate, the Participant must work 120 hours per month in Covered Employment to continue his or her eligibility. **The number of hours required to maintain eligibility each month could increase in the future, at the Board of Trustees discretion.** In addition, Employers may not always report on a full calendar month due to their specific payroll cut offs and therefore hours reported are based on ONLY those hours reported by your Employer and not necessarily all hours worked in a given calendar month.

This charge is made against your accumulated reserve hours when sufficient hours remain in reserve. If you work more than 120 hours during a month, the excess hours will be banked in your reserve account. Hours worked in one month shall not apply toward coverage the next month, but in the second following month. For example, hours earned in March will provide coverage in May.

After 12 months of no activity, a member's reserve account is removed, and upon return to work in the local union, the member must re-qualify for eligibility.

2. Maximum Reserve (12 Months Reserve).

You may accumulate a reserve not to exceed 1440 hours (not to exceed 12 month reserve), to be used in the future to supplement insufficient hours and shall have no credit for hours reported in reserve exceeding 1440 hours.

3. Limits and Rules Regarding Reserve Hours—No Vested Right.

Coverage for Employees is based on the accrual of hours at the current contribution rate, determined by the Board of Trustees, for the accumulation of hours in a Participant's Reserve Hour Bank. Hours are credited for actual work hours in a particular month. Thus, hours reported late because of late contributions, reciprocity or because of insufficient payments discovered through a payroll audit may not increase your Reserve Hour Bank.

You do not have a vested right to your Reserve Hour bank. The Board could reduce and/or cancel these hours at any time. In addition, Employers do not always report on a full calendar month due to their specific payroll cut offs and therefore hours reported are based on ONLY those hours reported by your Employer and not necessarily all hours worked in a given calendar month.

If you have not had coverage for a period of twelve consecutive months or more, any residual hours in your Reserve Account are forfeited; and thereafter, should you again perform work covered by the Collective Bargaining Agreement, or through the National Reciprocity plan as applicable, you are required to reestablish eligibility under the "INITIAL ELIGIBILITY" provision above.

4. Adjustment for Nonstandard Contribution Rate (Incoming Reciprocity).

If your Employer's contribution rate is different from the Collective Bargaining Agreement contribution rate, the credit to your Hour Bank may be multiplied by a percentage that results from dividing your Employer's contribution rate by the Collective Bargaining Agreement contribution rate, and then adjusted further for differences in work week or benefit level.

D. RECIPROCITY/AUTHORIZATION TO TRANSFER FUND (ERTS).

When you, as an IBEW Local 617-member, work outside the IBEW Local 617 area, you may request that your Health and Welfare Employer contributions be transferred to this Plan. The Plan participates in the Electronic Reciprocal Transfer System, known as ERTS. If you work outside the jurisdiction of IBEW Local 617 and wish to have your benefits sent back to this Trust Fund, you must register with ERTS before beginning work on that job**.** The effective date of the transfer is the first day of the month in which you have properly registered on ERTS and met the Home Plan eligibility requirements described in subsection (h). The Reciprocal Agreement provides that, upon approval of your application, contributions will be transferred to the Plan to the extent of the lesser of (i) the amount provided in the current Collective Bargaining Agreement or (ii) the amount provided in the current collective bargaining agreement of the Participating Fund. If the Collective Bargaining Agreement's contribution rate is greater than the contribution rate in the Participating Fund's collective bargaining agreement, your credit will be adjusted. ALERT: **A delay in signing the form will delay and/or prohibit the transfer of contributions to this Plan**.

Individual participants (traveling employees) must initially register on ERTS in person (with photo identification) at an assisting Local Union Office. At that time, they must sign the Participant Verification Page thereby agreeing to both the approved Authorization and Release(s) regarding reciprocal transfers under the Agreement(s) and the legally binding effect of utilization of an electronic signature on ERTS. Once they have completed their initial registration, Participants will receive their user ID and password in the mail at the address provided when they register with ERTS. After that they will be able to logon via the internet from any location using their user ID and password.

E. COVERED DEPENDENTS: Spouse and Children.

(a) Lawful Dependent Spouse. Your lawful spouse (husband or wife including a same sex spouse) is an eligible Dependent under the Plan. In the event of marriage, coverage is effective on the first date of the following month of the date of marriage, provided that you have submitted an Enrollment Form and copy of your certified marriage certificate within 30 days of the date of marriage. If proper documentation and your Enrollment Form is not received within 30 days of the date of marriage, enrollment of your Spouse will not be effective until the following open enrollment (unless there is a qualifying event). **California law and this Plan does not recognize common law marriage. However, you and your partner may qualify as Domestic Partners. Please Refer to Subsection 6 below for additional information regarding Domestic Partner eligibility and benefits.**

(b) Dependent Children. Your eligible Dependent Child(ren) are your (i) natural children, (ii) legally adopted children, (iii) stepchildren, and (iv) Child(ren) for whom the Participant has Court-Appointed Legal Guardianship. Your children are eligible for coverage through age 25 (up to the end of the month in which the child attains age 26). When you have eligible Dependent Children, each Dependent must be enrolled in

accordance with the Plan's procedures (outlined below). Upon enrollment, a Dependent Child will be eligible when a Participant's eligibility is effective and/or when he or she qualifies as an eligible dependent.

(c) Termination of Dependent Coverage. A dependent's eligibility will terminate when the Participant's coverage terminates, or when the individual ceases to be an eligible Dependent. You must immediately notify the Plan Office when an eligible Dependent ceases to meet the definition of an eligible Dependent.

(d) When completing an Enrollment Form you are indicating that the Dependents listed meet all requirements listed above. If you acquire a Spouse through marriage, have a child or adopt a child, and wish to enroll your new Spouse or child(ren) in your elected medical Plan, you must do so no later than **30 days** after the marriage, birth, adoption or placement for adoption. **Failure to notify the Plan Office within 30 days of a dependent's change in eligibility status may be considered fraud and could result in a request for reimbursement of any overpayments; and/or loss of certain extensions of coverage (i.e., COBRA) for the ineligible Dependent.** The Participant and ineligible Dependent may also be responsible for attorney fees or other associated costs incurred by the Plan as a result of maintaining an ineligible Dependent.

The Plan reserves the right to periodically request supporting documentation or written verification that an enrolled Dependent continues to meet Plan Dependent requirements (i.e., written confirmation and/or documentation that a spouse still resides with you etc.).

(e) Overage Disabled Dependent Child(ren). A Disabled Dependent Child of an Active or Retired Participant whose coverage would otherwise terminate solely due to attainment of Age 26 may continue to be eligible for coverage under the Plan as an Eligible Dependent provided that ALL of the following conditions are meet:

(1) The Dependent Child(ren) became totally and permanently disabled and incapable of self-sustaining employment by reason of mental or physical handicap prior to Age 26 while enrolled and covered under the Plan;

(2) The Participant remains currently eligible under the Plan and if required has submitted the full monthly premium to cover its Dependent Child(ren);

(3) The Participant and/or Dependent Child(ren) has taken action prior to attainment of Age 26 to obtain governmental benefits that are available and submits proof that the Disabled Dependent Child(ren) (within 30 days of the Dependent Child(ren)'s 26th birthday has:

(i) Certification of total and permanent disability from a licensed physician; and
(ii) Applied for Social Security Disability Benefits and must submit a copy of the Social Security Administration Disability Award letter; or if the Social Security Administration has denied the Disabled Dependent Child(ren)'s application, an Outside Independent Medical Review organization will need to certify that the child(ren)'s disabling conditions are total and permanent. The Participant/Dependent Child(ren) would be required to sign an authorization to release medical records in order to initiate such review; and

(4) In order to continuously maintain coverage under the Plan, the Dependent Child(ren) remains totally, permanently and continuously disabled as determined by the Plan or its authorized delegates. As such the Trust Fund office may require you (upon request) to periodically submit disability documentation on an annual basis.

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

CHANGES IN DEPENDENT STATUS – NOTIFY THE PLAN

It is the Participant's and/or dependent's responsibility to notify the Plan Office immediately when a Dependent's status changes. This includes a Spouse or other Dependent no longer residing with the Participant, divorce/final dissolution of marriage, legal separation, a Dependent child over 25 and any other events which would no longer make your dependent eligible for coverage. If claims are paid for, or premiums are paid on behalf of, any Dependent spouse or child and it is later found that the dependent was not eligible, **you and the Dependent will be responsible for reimbursing the Plan for the actual amount paid out in benefits by the Trust plus interest and any costs and attorney's fees.**

An apprentice is eligible to participate in the Plan as of the first day of the month following completion of 300 on the job hours. An apprentice is only eligible for coverage under the self-funded Blue Cross Prudent Buyer PPO Plan. An apprentice is eligible for dental and vision benefits after completion of 2000 hours of on-the-job training.

IMPORTANT NOTICE:
WARNING ABOUT FRAUD AGAINST PLAN

It is both the Participant's and Dependent's responsibility to notify the Plan Office immediately when the status of a Spouse, Child or other Dependent changes. This includes divorce/final dissolution of marriage, legal separation, death, a child attaining age 26 and any other events which would make your dependent not eligible for future coverage. If claims are paid for, or premiums are paid on behalf of any Spouse (or former spouse), child or other Dependent and it is later found that the individual was not eligible, you and the Dependent will be responsible for reimbursing the Plan for the amounts paid plus interest and any costs and attorney's fees incurred to recover the money.

F. DOMESTIC PARTNERS: An eligible and covered Participant's Domestic Partner will be covered provided the domestic partnership meets all of the following criteria:

1. Both persons must file a Declaration of the Domestic Partnership with the Secretary of the State of California and provide a copy to the Plan Office;[1]

2. Both persons to be two adults who have chosen to share on another's lives in an intimate and committed relationship of mutual caring;

3. Neither person may be married to someone else or be a member of another domestic partnership with someone else that has not been terminated, dissolved or adjudged a nullity;

4. The two persons must not be related by blood in any way that would prevent them from being married to each other;

[1] For those Participants who do not live in the State of California and are, therefore, not eligible to file a Declaration of Domestic Partnership with the Secretary of State's Office, the Fund will accept a properly completed Affidavit of Domestic Partnership as proof of the domestic partnership so long as the criteria set forth in 2-7 above is met. The Plan Office will provide Participants with the Affidavit upon request.

5. Both persons are at least 18 years old; and

Both persons must be capable of consenting to domestic partnership.
For Non-California Domestic Partnerships, you will be required to register such Domestic Partnership with the State of California and must meet the requirements above in order to be eligible for coverage under the Plan.

Domestic Partner No Longer Qualifies. In addition to the above requirements, both the Covered Participant and the Domestic Partner agree to inform the Plan Office of the termination of their domestic partnership as a result of a change in one or more of the above requirements or the death of the domestic partner. It is the Participant's responsibility to notify the Fund Office once a Domestic Partner no longer meets the Plan's Domestic Partner eligibility requirements. A Participant who fails to notify the Fund Office within 30 days of the date that a Domestic Partner has a change in eligibility status will be legally responsible for any payments or premiums made by the Plan from the date the Domestic Partner became ineligible for coverage. Eligibility of a Domestic Partner shall terminate on the date the Domestic Partner no longer meets the Plan's eligibility requirements including lack of timely payment of the imputed income taxes.

Imputed Income. The election by a Covered Participant to add a domestic partner may have certain Federal income tax implications. Under Federal tax law, the fair market value of health coverage provided to a domestic partner is a taxable benefit to the Participant. (Please note that domestic partner benefits are not taxable under California law.) Each year the Fund will calculate the fair market value of the domestic partner coverage and this information will be sent to participating employers. The Participant's employer is then responsible for including the imputed income on the Participant's wages and withholding any FICA, FUTA, Medicare and Federal income taxes as applicable.

Proof of Continuing Eligibility. The Plan may require evidence of continued domestic partnership status at any time.

G. AUTOMATIC COVERAGE FOR NEWBORN CHILD- If Plan Notified Within 31 Days: A newborn or newly adopted child will automatically be covered for the first 30 days of medical benefits on the date the child becomes a Dependent. However, you are required to apply for Dependent coverage for that child within 30 days of the child's birth or of the adopted child's placement in your home in order to continue that child's coverage beyond the first 30 days. You are urged, however, to enroll the new child immediately. **If you fail to do so, there is no coverage, and you MUST WAIT UNTIL THE NEXT ANNUAL OPEN ENROLLMENT PERIOD TO ENROLL THE CHILD.**

H. QUALIFIED MEDICAL CHILD SUPPORT ORDERS (QMSCO) (including National Medical Support Notice):

The Participant must timely provide the Plan Office with a copy of any court order that establishes the Participant's legal obligation to maintain coverage on a Dependent Child (known as an "alternate recipient"). The Plan will recognize a Qualified Medical Child Support Order ("QMCSO"), including a properly completed National Medical Support Notice ("NMSN") that meets the requirements of the Employee Retirement Income Security Act ("ERISA"). In general, a QMCSO recognizes an eligible child's right to receive Plan benefits as a beneficiary of an eligible Plan Participant. The child, to be covered for benefits by this Plan, must meet Plan requirements for an eligible Dependent child including age requirements (under Age 26).

The steps that the Plan office will follow to establish and determine whether a court order would qualify as a QMCSO are:

1. The Participant must provide the Plan Office with a copy of the court order and/or QMCSO and/or NMSN.

2. Within thirty (30) days after receipt of the QMCSO and/or NMSN, the Plan Office or the Plan's legal counsel will notify the Participant in writing if the court order and/or QMCSO and/or NMSN is acceptable to the Plan.

3. If the Plan determines that the court order and/or QMCSO and/or NMSN is not acceptable, or if additional information is required, the Participant will be notified in writing by the Plan or the Plan's legal counsel.

a) **If a QMCSO and/or NMSN is denied**. The notice will describe the reasons for denial. There is a right to appeal a denial. A summary of the Plan's appeal procedures will be included in the notice of denial. In most instances however, you will simply be asked to revise the order in such a way that it is a proper QMCSO and/or qualified NMSN.

b) **If additional information is required**. The notice will describe what is needed. There will be sixty (60) days to respond. If you do not respond within the sixty (60) days, the request for the QMCSO will be deemed canceled.

4. A medical child support order is qualified if it:

(1) creates or recognizes an alternate recipient's right to receive benefits for which a participant or beneficiary is eligible to receive under a group health plan, or
(2) assigns to an alternate recipient the right to receive such benefits; and
(3) In addition, for an order to be a QMCSO/NMSN it must clearly specify the following information:

i. Name and last known mailing address of the participant and of each alternate recipient covered by the Order,
ii. Reasonable description of the type of coverage the plan is to provide to each alternate recipient or the manner in which the coverage is to be determined; and
iii. Period to which the QMCSO applies.

5. The order will fail to be a QMCSO/NMSN if it requires the Plan to provide any type or form of benefit, or any option not otherwise provided under the Plan, except to the extent necessary to meet the requirements of a state law relating to medical child support.

6. The Plan requires that the Participant and all of his eligible Dependents be enrolled under only one Health Plan option. Therefore, a Participant must select and enroll in a Health Plan option that would be available to the Participant, the child(ren) covered under the QMCSO and./or NMSN and to the Participant's other eligible Dependents. If a Participant enrolls in a Plan that would not be available to the child(ren) covered under the QMCSO and/or NMSN because they reside outside of the Plan's service area, the Participant will be required to enroll in another Health Plan option that would cover the child(ren). The Plan will follow the requirements of the QMCSO and/or NMSN even if it requires that the Participant be forced to enroll in a different Plan option.

7. Please be aware that if a child covered under a QMCSO and/or NMSN was enrolled independent of the Participant neither the Participant nor any other Dependents would be considered enrolled in the Plan until such time as the Participant has completed all Enrollment Procedures. In addition, the Participant and any other eligible Dependents would then be limited to enrollment into only that Health Plan option that the child covered under the QMCSO and/or NMSN has been enrolled in.

8. Limited Purpose of Plan's Review of Order. The Plan does not review child medical support orders to determine whether they are fair or complete, or whether they comply with applicable state law. The Plan

looks only to see whether an order contains language about medical benefits which creates or recognizes the existence of an alternate recipient's right to receive benefits payable by this Plan.

I. <u>FAMILY MEDICAL LEAVE ACT (FMLA) Continuation of Health Coverage</u>: If your Employer has at least 50 Employees, your Employer may be required to continue to pay for your health coverage on the same terms as if you had continued work, during any approved leave under the Federal Family and Medical Leave Act of 1993 (FMLA). In general, you may qualify for up to 12 weeks of unpaid FMLA leave per year if:

(1) You worked for the Employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months (except if you are requesting a Temporary Emergency Expanded FMLA leave pursuant to the Families First Coronavirus Response Act, as indicated below in Subsection 2.vi. the 1,250 hours requirement does not apply and instead an employee only has to be employed for at least 30 calendar days); and

(2) You require leave for one of the following reasons:

(i) Birth of a child and to care for the newborn child within one year of birth;
(ii) Placement of a child for adoption of foster care and to care for the newly placed child within one year of placement;
(iii) Care for your child, spouse or parent with a serious medical (including mental health) condition;
(iv) Your own serious health (including mental health) condition that makes you unable to perform the essential functions of your job;
(v) Military Caregiver Leave (up to twenty-six (26) weeks during a 12-month period). Care for your spouse, son, daughter, parent, or next of kin who is a member of the Armed Forces (including the National Guard or Reserves), and undergoing medical treatment, recuperation, or therapy for a serious injury or illness; or
(vi) If you are unable to work or telework due to the care of your son or daughter because of the closure of the child's school or place of care or the unavailability of a childcare provider due a public health emergency which is defined as an emergency with respect to COVID-19 declared by a Federal, State or local authority (during the period of April 1, 2020 through December 31, 2020 only); or
(vii) Any other purpose provided for by the FMLA.

A "Serious medical including mental health condition" means if it requires inpatient care, or continuing treatment by a health care provider.

Coverage will not be continued beyond the earlier of:

- Date contributions are not timely made;
- Date your Employer determines your approved FMLA leave is terminated; or
- Date your coverage involved discontinues as to your eligible class.

Details concerning FMLA leave are available from your Employer. If your Employer grants you an approved FMLA leave in accordance with FMLA, you may continue health coverage for you and your eligible dependents provided your Employer maintains the required contributions to the Plan on your behalf or you make any required contributions to the Plan. Requests for FMLA leave must be directed to your Employer. The Plan Office cannot determine whether or not you qualify. If you are requesting Emergency Expanded FMLA leave during April 1, 2020 through December 31, 2020, please contact your employer regarding taking Emergency Expanded FMLA leave.

If your coverage terminates because your approved FMLA leave is deemed terminated by your Employer or you fail to return to work after exhausting your FMLA leave, you may, on the date of such termination, be eligible for COBRA continuation coverage under Federal law, on the same terms as though your employment terminated, other than for gross misconduct, on such date. If a dispute arises between you and your Employer concerning your eligibility for FMLA leave, you may continue your health coverage by making COBRA self-payments. If the dispute is resolved in your favor, and your Employer makes the required contributions, the Plan may refund the corresponding COBRA payments to you.

NOTE: If your Employer continues your coverage during an FMLA leave and you fail to return to work, you may be required to repay the Employer for all contributions paid to the Plan for your coverage during the leave.

It is the responsibility of your Employer (not the Plan) to notify you of your rights under FMLA and to approve your request for FMLA leave. It will be your responsibility to notify your Employer that FMLA leave is being taken.

J. SPECIAL ENROLLMENT RIGHTS.

Other than during Open Enrollment, the Plan is required to provide Special Enrollment Rights to you and your eligible Dependents upon the following events:

1. Loss of Other Coverage: If you did not enroll your eligible Dependents because your Dependents had other group health coverage or other health insurance, including COBRA continuation coverage, and showed the Plan Office evidence of such other coverage, your eligible Dependents may enroll in this Plan during a Special Enrollment period. This Special Enrollment period is a 30-day period which begins when you lose the other coverage. To take advantage of this Special Enrollment Right, your Dependents must enroll in the Plan within 30 days of exhausting COBRA continuation coverage or the termination of such other coverage as a result of a loss of eligibility for coverage (such as a divorce, legal separation, death, termination of employment, reduction in the number of hours, ceasing to reside, live or work in the HMO service area if no other coverage is available under the other plan, or dependent ceasing to qualify as a dependent under the other plan).

2. Acquire New Dependents: Newly acquired eligible Dependents, including your legal spouse, newborn, adopted child(ren) or step child(ren), will be covered from the time of birth, adoption, placement for adoption, or marriage provided you complete and submit an Enrollment Form and appropriate documentation to the Plan Office within 30 days of the birth, adoption, placement for adoption, or marriage.

3. Special Enrollment Allowed Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIP): The Children's Health Insurance Program Reauthorization Act of 2009 (CHIP) created a special enrollment period that applies to group health plans, similar to those currently in effect for the loss of eligibility for other group coverage or qualifying life status changes. Under this Act, group health plans must permit yourself and/or your eligible dependents with group health plan coverage to enroll in the Plan if they:

- Lose eligibility for Medicaid or CHIP coverage; or
- Become eligible to participate in a premium assistance program under Medicaid or CHIP

In both cases you and/or your eligible dependent must request special enrollment within 60 days (of the loss of Medicaid/CHIP or gaining eligibility for premium assistance under Medicaid or CHIP, as applicable. More information is available at *www.coveredca.net* or *www.dhcs.ca.gov/services/medi-cal*.

III. RETIREE ELIGIBILITY

The Board of Trustees established Retiree medical benefits on the basis that Employer contributions for Active Participants will, if continued, partially maintain benefits for retirees. You will be required to pay a portion or all of the cost of coverage for retiree benefits. Retirees eligible for retiree coverage are required to pay a monthly premium to the Plan based on the Medicare status of the retiree and other eligible enrolled Dependents. The due date for your self-payment is the 20th of the month PRIOR TO THE MONTH OF COVERAGE. Retirees are billed quarterly.

It is recognized that the benefits provided by this Plan can be paid to the extent that the Plan has available adequate resources for those payments. You should contact the Trust Fund Office for current rates.

The Board of Trustees may change the rates at any time. Benefits under this Plan are not vested and can be changed or eliminated at any time. Monthly premium payments for Retirees are likely to increase.

A. ELIGIBILITY RULE.

1. Eligibility Rules – Retirees. Participants and their eligible dependents who are or have been eligible under the Plan as an Active Participant, for ten (10) of the last 15 years and two (2)of the last 5 years immediately preceding age 55 or older (date of retirement) and has coverage at their retirement date, are eligible for the Retiree Plan health and welfare benefits then in effect, if any. **There currently is a charge for the Retiree benefits.**

An eligible Retiree's effective date is the 1st day of the month following the date they meet the above requirements, and remits the premium contribution for the applicable coverage. The cost to the Retiree for health and welfare benefits will depend upon the amount of future Employer contributions made on their behalf and the Plan's earnings, expenses and asset appreciation or depreciation. **Disability Income, Life and AD&D coverage cease as of the date retiree health benefits begin.**

1. Totally and Permanently Disabled. A Participant who otherwise qualifies for early or regular retirement (except for reaching age 55), who becomes or is Totally and Permanently Disabled as determined by the Social Security Administration at any age, shall be eligible for retiree medical benefits under the Plan upon paying the required premium established by the Board of Trustees.

2. Return to Covered Employment. A Participant who has attained age fifty-five (55) or older and has retired under the San Mateo Electrical Construction Industry Retirement Plan and begun participation in the Retiree portion of the Health Plan will remain a Participant in the Retiree portion of the Plan (and pay the designated premium) even if such retiree returns to part or full-time covered employment. If such a Participant works in covered Employment up to 40 hours during a calendar month, the Employer contributions made on their behalf for the hours worked will be used to offset the required retiree premium, with any remainder to be paid by the Participant. If the hours reported for such a Participant (who had previously retired) exceed the hour requirement for retired Participants per calendar month (more than 40 hours), the excess Employer contributions made on the Participant's behalf shall be retained by the Plan.

B. RETIREE HOUR BANK CONVERSION.

An eligible Retiree's Hour Bank and funds will be transferred from the San Mateo Electrical Workers Health Care Benefits Plan (Active Plan) to the Retired San Mateo Electrical Workers Health Care Benefits Plan (Retiree Plan) on the effective date of retirement. (Although described as a separate Plan, there is only one Plan.) This money will be held in account and can be used by the Retiree to pay monthly contributions to the Retiree Plan.

The dollar amount to be transferred will be the equivalent of the current cost of (Active Plan) monthly benefits, multiplied by the number of full months (Hour Bank balance divided by 120) in the Retiree's Hour Bank. As an example: If the Retiree has 720 hours in his or her Hour Bank at retirement, and the current monthly cost for coverage is $700, then the Retiree would receive (720 hours/120 = 6 months x $700) $4,200 in his or her account.

C. MEDICARE COORDINATION--YOU ARE REQUIRED TO ENROLL.

1. Summary of Medicare. Medicare is our country's federal health insurance program for people who worked at least 10 years in Medicare Covered employment who are age 65 or older, for people under age 65 with certain disabilities, and for people of any age who have End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). If you are receiving Social Security Disability Income (SSDI) benefits, you generally become eligible for Medicare coverage 24 months after your SSDI benefits begin. If you are not a citizen or permanent U.S. resident, you may not qualify for Medicare. **If you or your Spouse becomes eligible for Medicare, you should carefully read this section. It will tell you what your obligations are concerning enrolling in Medicare Part A and B, how the Plan pays when you are eligible for Medicare, and other important information you need to know.**

Medicare has four parts:

- **Medicare Part A – Hospital Insurance**. Part A covers inpatient care and certain skilled nursing facilities. Generally, there is no monthly premium, but there are annual deductibles and co-insurance/co-payments after certain lengths of stay.
- **Medicare Part B – Medical Insurance**. Part B covers medical and doctor services, outpatient hospital care and other services. Part B requires payment of a monthly premium, as well as deductibles and co-insurance/co-payments. The member pays an annual deductible and 20% coinsurance. Members continue to pay the Part B premium monthly out of their Social Security check.
  You should enroll in Part B when first eligible to avoid a financial penalty and a potential delay in your enrollment.
- **Medicare Part C – Medicare Advantage Plans**. Health plan options approved by Medicare and administered by private companies.
- **Medicare Part D – Prescription Drug Coverage**. Provided through plans run by insurance companies or other private companies approved by Medicare. There are monthly premiums, deductibles and co-insurance/co-payments.

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

Medicare Part A is financed by payroll taxes, and, if you are eligible to receive it based on your own or your spouse's employment, you do not pay a premium. Medicare Part B is partly financed by monthly premiums

paid by individuals enrolled for Part B coverage. Most people are entitled to Part A when they turn age 65 and pay no premium because they or a spouse paid Medicare taxes while working.

The Plan coordinates benefits with Medicare as if you are covered under both Medicare Part A (hospital benefits) such as hospital inpatient care and skilled nursing facilities (but not custodial or long-term care) and Part B (medical benefits such as medical and doctor services, outpatient hospital care and other services). This means you must enroll in **both Medicare Part A and Part B**, as soon as you are eligible for Medicare. If you do not enroll in Medicare (Part A and Part B), the Plan will not make up for the portion of expenses that Medicare would have paid and you will be required to pay an additional Retiree Health and Welfare Premium.

However, if you or your spouse are still working (after reaching Age 65), Medicare works a little differently. Generally, if you have job-based health insurance through your (or your spouse's) current job, you don't have to sign up for Medicare while you (or your spouse) are still working. You can wait to sign up until you (or your spouse) stop working or you lose your health insurance (whichever comes first).

IMPORTANT NOTICE: ENROLL IN MEDICARE

To be eligible for Retiree Health and Welfare benefits under this Plan you and/or your eligible Dependent(s) are required to enroll in both Medicare Parts A and B and pay the required premium (for part B) as soon as you and/or your eligible Dependent(s) are entitled to coverage. ***Note: Because Medicare benefits are assigned to your medical plan, you and/or your eligible Dependents can only enroll in one HMO Medicare Plan.***

It is important that you enroll in Medicare Part B when you first become eligible. If you do not, Medicare generally imposes penalties which will significantly increase your Part B premium once you do enroll. The cost of Medicare Part B premium will go up 10% for each full 12-month period an individual was eligible for Medicare Part B during the initial enrollment period but did not enroll. If you did not enroll when first eligible, and later choose to enroll, you must wait until the next Medicare Part B open enrollment period, which is January 1 through March 31 of each year. Your Medicare Part B will be effective on July 1 of the year you enroll. **For enrollment and eligibility information, you should call Social Security at (800) 772-1213. You can also find Medicare information on the Internet at www.medicare.gov.**

To avoid loss of protection, you (or your Dependents) must enroll for Parts A and B of the Federal program during the **three months** before the month in which you (or your Dependents) will become eligible for Medicare. Social Security will automatically enroll you in Medicare Parts A and B. If you have not received your Medicare Card within 2 months of your Medicare eligibility, you should contact the Social Security Administration. **Please remember that if you and/or your Dependent are under age 65 but eligible for Medicare, you and/or your Dependent must also enroll for Parts A and B.**

EXAMPLE: Below is an example of why it is important for Medicare-eligible individuals to enroll in Medicare Part B coverage.

Assume Bob, a Medicare-eligible Retiree, requires a medical service and most physicians charge $150.00 for it. Assume that Medicare's allowed amount for the services is $100.00, that Medicare would pay 80% of the allowed amount and that the Plan would pay the 20% co-insurance. If Bob is enrolled in Medicare Part B, and has satisfied the Part B deductible, the Plan would pay $20.00 because Medicare would have paid $80.00, and the claim would be considered paid in full. However, if Bob is eligible for but not enrolled in Medicare Part B, then the Plan will still pay $20.00 and Medicare will pay nothing. Consequently, Bob is responsible for $130.00 ($150.00 minus $20.00 paid by the Plan).

Effective January 1, 2006, Medicare eligible individuals were given the option of enrolling in the Medicare Part D prescription drug program. Prescription drug coverage in the Plan is not affected by the Medicare Part D prescription drug program and **it is not necessary for you to enroll in Medicare Part D**. The prescription drug benefits you currently receive under this Plan provide better coverage, at less cost to you, than the new drug program under Medicare Part D. As long as you are eligible for a prescription drug plan that has coverage that is equal to or better than what is offered under Medicare Part D, you are considered to have "Creditable Coverage"; therefore, if at some later date you choose to enroll in Medicare Part D, you will not be charged a late penalty for delayed enrollment.

2. Medical Plans for EARLY NON-MEDICARE Retirees. (Kaiser Permanente HMO Plan and Anthem Blue Cross Options). The Kaiser Permanente HMO plan and Anthem Blue Cross PPO plan are available to Early Retired Participants and their eligible Dependent(s) who are not enrolled in Medicare and who reside in a Northern California Kaiser or Anthem Blue Cross service area. Please be aware that the Participant and all eligible Dependents can only be enrolled in one Health Plan option. Therefore, a Dependent's eligibility to enroll in these Plans would depend on the Health Plan option selected by the Participant.

If you have any questions regarding the Kaiser HMO Plan or require additional information, please call a Kaiser Customer Services Representative at (800) 464-4000.

If you have any questions regarding the Anthem Blue Cross Plan or require any additional information, please call Anthem at (800) 688-3828.

3. Medical Plans for MEDICARE Retirees. (Kaiser Permanente Senior Advantage (HMO), Blue Shield of CA Medicare Supplement Plan, and Hartford Medicare Supplement Plan).

Medicare Retirees and their eligible Dependent(s) have the option of one of the following medical options depending on where they reside:

- **a.** **Kaiser Permanente Senior Advantage (HMO).** Eligible to Retired Participants and their Dependents who are enrolled in Medicare Part A and Part B and who reside in the Northern California Kaiser service area.
- **b.** **Blue Shield of CA Medicare Supplement Plan.** Eligible to Retired Participants and their Dependents who are enrolled in Medicare Part A and Part B and who reside in the Blue Shield of CA service area.
- **c.** **Hartford Medicare Supplement Plan.** Eligible to Retired Participants and their Dependents who are enrolled in Medicare Part A and Part B and who reside out of state.

Retirees with Medicare who enroll in Kaiser or the Blue Shield plans MUST assign their Medicare benefits to Kaiser or Blue Shield (whichever is applicable). The Plan Office will send you a Medicare authorization form when you become eligible for Medicare. Please be aware that generally the Medicare Participant and all eligible Medicare Dependents can only be enrolled in one Health Plan option. Therefore, a Medicare Dependent's eligibility to enroll in these Plans would depend on the Health Plan option selected by the Medicare Participant. However, if the member is on Medicare but the Dependents are **not on Medicare**, then the Non-Medicare Dependents will have the option of the Anthem Blue Cross Plan or Kaiser. That means the Non-Medicare Dependent(s) can be on a separate plan (ex. Kaiser HMO or Anthem PPO Blue Cross Plan) from the Medicare Participant.

If you have any questions regarding the Kaiser Permanente Senior Advantage Program, or require additional information, please call a Kaiser Customer Services Representative at (800) 747-2189.

If you have any questions regarding the Blue Shield of CA Program, or require additional information, please call a Blue Shield Customer Services Representative at (855) 385-3820.

If you have any questions regarding the Hartford Medicare Program, or require additional information, please call the Trust Fund Office.

d. Other Benefits (For Retirees)

Dental. The Plan provides dental care through an insured arrangement through Delta Dental with Group Number 2776-003. A separate booklet is available at the Plan Office which describes this coverage. Please refer to the Dental Benefits section of these Plan rules for more information.

Vision. Your vision benefits are provided through VSP (For Blue Shield participants only). Please refer to the Vision Benefits section of these Plan rules for more information. When you see a VSP provider, you'll get the most out of your benefit, have lower out-of-pocket costs, and your satisfaction is guaranteed. Using your vision benefits:

A. Register at vsp.com. Once your plan is effective, review your benefit information.
B. Find an eyecare provider who is right for you. The decision is yours to make – choose a VSP provider or any out-of-network provider. To find a VSP provider, visit vsp.com or call (800) 877-7195.
C. At your appointment, tell them you have VSP. There is no ID card necessary. If you would like a card as a reference, you can print one on vsp.com.
D. There are no claim forms to complete when you see a VSP provider.

Hearing Care. Please refer to Hearing Benefits section of these Plan rules for more information.

D. COST FOR RETIREES. (Contact the Plan for the rates in future years.)

In-State Medicare Retirees. Retirees who reside in the Retiree Plan's approved California Medicare Supplement or Medicare HMO Plan service area are eligible for a Medicare Supplement or Medicare HMO Plan, Prescription Drug, Dental and Vision coverage. The cost to the retiree will vary depending on whether you are single, whether you are a couple with a spouse under age 65 or you are a couple with a spouse over age 65.

Out-of-State Medicare Retirees. Retirees who reside outside of the Retiree Plan's approved California Medicare Supplement or Medicare HMO Plan service area are eligible to purchase coverage under the Retiree Plan's approved Medicare Supplemental Plan, for out-of-state retirees, up to the same rate as in-state Medicare Retirees. This benefit may be changed at any time.

Please refer to the Benefits Website or contact the Trust Fund office for the retiree rates, which usually changes each year.

THESE AMOUNTS WILL INCREASE IN MOST IF NOT ALL YEARS.

E. WIDOWS/WIDOWERS OF RETIREES-MEDICARE.

Widows/widowers (age 65 or older) of Retirees must be covered by the Plan at the time of the Retiree's death to be eligible for coverage.

1. Age 65 or Older

a. Widows/Widowers of Retirees residing in the Retiree Plan's approved California Medicare Supplement of Medicare HMO Plan service area, are eligible for Medicare Supplement or Medicare HMO plan, Prescription Drug, Dental and Vision coverage. To obtain the amount of the premium, please refer to the rate sheet posted on the Benefits Website or contact the Trust Fund office.

b. Widows/Widowers of Retirees residing outside the Retiree Plan's approved California Medicare Supplement or Medicare HMO Plan service are entitled to the Retiree Plan's approved Medicare Supplemental Plan up to the same rate as in-state Medicare Retirees and rates will vary depending on the age of the Widow/Widower.

c. Widows/Widowers-Medicare who re-marries, may elect to continue coverage for themselves only and must self-pay the full premium for Medicare Supplement or Medicare HMO plan, Prescription Drug, Dental and Vision Plans.

2. Divorced Spouses of Retirees-Medicare

a. Divorced spouses (under age 65) will cease to be eligible for coverage under the Plan effective the 1st day of the month following the date of the divorce in final. The divorced spouse may elect to continue coverage through COBRA for thirty-six months, or extended COBRA, if eligible. It is the member's responsibility to notify the Trust Fund Office of the divorce.

b. Divorce spouses (age 65 or older) who are covered by the California Medicare Supplement or Medicare HMO Plan, will cease to be eligible for Medical, Prescription Drug, Dental and Vision coverage under the Plan effective the 1st day of the month following the date the divorce in final. The divorced spouse may elect to continue the Medicare Supplement or Medicare HMO coverage only, by paying the full premium. It is the member's responsibility to notify the Trust Fund Office of the divorce.

F. OPTING OUT OF THE RETIREE HEALTH AND WELFARE PLAN.

If you are eligible and have enrolled in Retiree Health and Welfare Plan but subsequently wish to opt out (dis-enroll) from this Plan, you must submit a written request to the Plan Office. Please be aware that opting out of the Retiree Health and Welfare Plan benefits terminates all Retiree benefits including Medical, Prescription Drug, Dental and Vision.

If you are not currently eligible for Medicare Benefits, you will be dis-enrolled the first of the following month after your request has been received and processed by the Plan Office. If you are eligible for Medicare benefits and are currently enrolled in the Kaiser or Blue Shield Medicare HMO programs, you will be dis-enrolled as described below:

Kaiser (Senior Advantage) In addition to your written request, you must sign a Kaiser Disenrollment Form. Provided that your request is submitted in a timely manner, you will be dis-enrolled the first of the following month after you sign and submit the Disenrollment Form.

Blue Shield. In addition to your written request, you must sign a Blue Shield Disenrollment Form. Provided your request is submitted in a timely manner, you will be dis-enrolled the first of the following month after you sign and submit the Disenrollment Form.

PLEASE NOTE: Because Medicare requires time to process your disenrollment request, failure to dis-enroll on a timely basis may result in a lapse in utilizing your Medicare Benefits. Please contact the Plan Office if you need assistance.

Please be aware that if you opt out of the Retiree Health and Welfare benefits, you will not be permitted to opt back into the Plan except under the following conditions:

(1) In accordance with Plan rules, you may delay/opt out of your Retiree Health and Welfare benefits for yourself and/or your Dependent spouse until you/or your spouse becomes Medicare eligible, provided that you notify the Plan Office in writing within 30 days of the date that you/or your spouse become Medicare eligible. Please be aware that if you delay/opt out of Retiree Health and Welfare benefits, you will not be permitted back into the Plan until you become Medicare eligible. Also, please be aware that in order for a spouse to be eligible to opt back into the Plan based on Medicare entitlement, at the time of the spouse's Medicare eligibility the Retiree would have to already be eligible for and enrolled in Retiree Health and Welfare benefits.

(2) Plan rules also provide that if you and/or your Dependent(s) are eligible for coverage under another plan, you may also delay/opt of out of your Retiree Health and Welfare Benefits for yourself and/or eligible Dependents until your/their coverage under the other plan terminates, provided that you notify the Plan Office in writing within 30 days of the date the other coverage terminates and subject to proof of such termination of prior coverage (such as a copy of a HIPAA notification). Please be aware that in order for Dependents to be eligible to opt back into the Plan, the Retiree would have to be eligible for and enrolled in Retiree Health and Welfare Benefits.

G. RETIREE AND SURVIVING SPOUSE DISENROLLMENT PROCEDURES DUE TO CHANGE IN HEALTH PLANS.

If you are planning to move, you should contact the Plan Office in advance to obtain information regarding how your new address may affect your Retiree Health and Welfare Benefits. You will be required to submit a new Enrollment Form.

1. Non-Medicare Eligible Participants: If you are not currently eligible for Medicare Benefits, you will be dis-enrolled the first of the following month after your request has been received and processed by the Plan Office.

2. Medicare Eligible Participants: If you are eligible for Medicare Benefits and are currently enrolled in the Kaiser or Blue Shield Medicare HMO program and you move out of the Kaiser or Blue Shield Medicare Service Area, or you wish to switch from the Kaiser Medicare Plan to the Blue Shield Medicare Plan, or vice versa, you need to be dis-enrolled as described below:

Kaiser (Senior Advantage). In addition to your written request, you must sign a Kaiser Disenrollment Form. Provided that your request is submitted in a timely manner, you will be dis-enrolled the first of the following month after you sign and submit the Disenrollment Form.

Blue Shield. In addition to your written request, you must sign a Blue Shield Disenrollment Form. Provided your request is submitted in a timely manner, you will be dis-enrolled the first of the following month after you sign and submit the Disenrollment Form.

PLEASE NOTE: Because Medicare requires time to process your request for disenrollment, failure to dis-enroll on a timely basis may result in a lapse in utilizing your Medicare Benefits. Please contact the Plan Office if you need assistance.

H. NOTICE TO THOSE ELIGIBLE FOR MEDICARE PART D PRESCRIPTION DRUG COVERAGE.

The Federal Medicare Prescription Drug, Improvement and Modernization Act created a prescription drug benefit referred to as Medicare Part D Prescription Drug Coverage (Medicare Part D coverage or coverage). The coverage is available to all Medicare eligible employees and/or dependents that are age 65 or older or are disabled and are receiving Social Security disability benefits, and those with end stage renal disease. Generally, the open enrollment period for joining a Medicare Part D Drug plan is October 15th through December 7th. You can also join Medicare Part D drug plan when you first become eligible for Medicare or during a Special Enrollment period (which occurs when you lose your current creditable prescription drug coverage, through no fault of your own, you will be eligible for a two-month special enrollment period to join a Medicare Part D drug plan).

A Notice (titled "**Notice of Medicare Part D Creditable Coverage**") containing general information about Medicare Part D prescription drug coverage and this Plan is required to be provided to you (a Medicare eligible individual) by the Plan prior to each annual Medicare Part D enrollment period beginning on or around October. The Notice will help you decide whether or not you want to join a Medicare Drug plan compared to the prescription drug coverage being offered through the Plan. The Notice must also be provided to you prior to your initial enrollment period for Medicare Part D coverage, prior to the effective date of your enrollment in this Plan, whenever the Plan's prescription drug coverage ends or changes so that it is no longer considered "Creditable Coverage", and upon your request. "Prior to" means within 12 months before the event in question. "Creditable Coverage" means that the prescription drug plan offered by the Plan Sponsor is as generous as or more generous than the standard coverage under Medicare Part D prescription drug benefit. In other words, the expected value of claims paid under the plan is as much as the value of claims that would be paid under the standard Medicare Part D benefit. If your existing coverage is considered "Creditable Coverage" then you can keep that coverage and not pay a higher premium (a penalty) if you later decide to join a Medicare drug plan.

The Board of Trustees of this Plan intends to continue to provide a prescription drug benefit that is equivalent on a gross basis to Medicare Part D coverage, in other words Creditable Coverage. Therefore, there is no requirement that you enroll in Medicare Part D when you become eligible. The Plan will notify you of these changes.

IV. SELF-PAYMENTS (Prior to COBRA)

To maintain continuous coverage, a Participant whose coverage has terminated or has insufficient hours for coverage, may elect to pay for continued coverage under one of the following two options:

A. <u>OPTION ONE: Subsidized Self Payment Option – Up to 12 Months.</u>

You may elect to continue the total benefit package (Medical and Dental and Vision coverage but keep in mind VSP is for PPO only) for up to twelve consecutive months, at a cost equal to 50% of the full amount of the cost of the benefits as determined by the Board of Trustees or a Participant may elect to continue the total package if actively seeking employment and is available for dispatch, has been dispatched, or is working in the jurisdiction of Local Union 617, at a cost to be determined periodically by the Board of Trustees.

If this option is selected, the twelve consecutive months of coverage provided shall run concurrently with the first twelve months of coverage under Option Two COBRA as if you or your eligible dependents were covered under Option Two initially. Should a dependent's coverage terminate under Option One (e.g., due to divorce or a dependent child losing eligibility because of age), that dependent may continue coverage under Option Two up to a maximum of thirty-six months of coverage under Option One and Option Two combined.

B. OPTION TWO: COBRA Option.

You may elect COBRA continuation coverage. For details, see the COBRA Article XXI on page 73.

C. EMPLOYEE STATED REQUIRED CALIFORNIA COVERAGE - If Labor Dispute.

Arrangements may be made to continue your coverage if you cease Active Work because of a labor dispute. You may continue your coverage up to six months, but only if certain conditions of the Insured arrangements are met. See your *Participating Employer* to make arrangements for continuing your coverage. Your coverage will be terminated unless you make arrangements within 31 days after you cease Active Work due to a labor dispute.

D. OPEN ENROLLMENT PERIOD.

The open enrollment period is from **April 15th to May 15th** of each year with the effective date of the change to be June 1st. If this date changes you will be notified.

E. MILITARY SERVICE.

Any eligible person who enters the military service or military training under the laws of the United States may elect to have coverage suspended by freezing reserve hours. This request must be made in writing to the Board of Trustees and will be effective the first day of the month following receipt of the request. You should notify the Plan in writing, as soon as you are aware that you will resume active work by sending a letter to the Plan Office.

F. UNIFORMED SERVICES EMPLOYMENT AND REEMPLOYMENT RIGHTS ACT (USERRA).

Under the Uniform Services Employment and Re-employment Rights Act ("USERRA"), your Employer must offer to continue coverage for you and your Dependents up to 24 months while you are on military leave of 31 days or more. Thus, if you enter full-time military service for a period in excess of 30 days, your coverage will terminate immediately. You may then purchase continuation coverage for you and your dependents under the rules included in the COBRA section described on page 31. You should notify the Plan Office if you enter military service for more than 30 days. However, you may elect to waive your rights under federal law. The months of coverage so applied would no longer be available to provide coverage upon your return to covered employment.

The following procedures are to be followed for a Participant who is a military reservist once called to active duty:

1. Upon notification that a Participant has been called to active duty, a Participant's hours will be frozen from the first day of the month following the date the employee begins active duty. Exception: If the Participant begins active duty on the first of any month, the Participant's hours will be frozen as of the first of that month.

2. The Plan Office will notify the Participant of the option to elect continuation of Medical, Dental, Disability, AD&D, Vision, and Life coverage by self-paying the premium to the Plan Office. Coverage may be continued for a period that is the lesser of 18 months, or a period that ends on the day the individual fails to apply for, or return to a position as an active Participant of the Plan.

To qualify for re-employment rights under USERRA, including continued health benefits, your leave must be for the purpose of entering a "uniformed service", which includes the Army, Navy, Air Force, Marine Corps, Coast Guard, National Guard (full time duty), Commissioned Corps of Public Health Service and anyone else designated as Covered by the President of the United States during time of war or National Emergency. In addition, you must return to your same Employer or Another Employer that contributes to the Plan, within a specified period of time, depending upon the length of time you are absent for military service, as follows:

- If your **service lasts less than 31 days**, you must be available for covered employment on the next calendar day (so long as you had at least 8 hours rest after returning home by normal transportation) following the end of your service.
- If your service lasts for **31 days or more but less than 181 days**, you must be available for covered employment no later than 14 days after the end of your service.
- If your service lasts for **more than 180 days**, you must be available for covered employment no later than 90 days following the end of your service.

If you are absent from covered employment as a result of military service for **less than 31 days,** you may elect to continue your coverage at no expense, for the first month.
If you are absent from covered employment as a result of military service for **31 days or more**, you may elect to purchase COBRA-like coverage for up to 24 months (the first month of which is free). Typical rights under COBRA are for 18 months, rather than the longer 24-month period. USERRA continuation coverage is similar but not identical to COBRA requirements. Any continuation coverage taken pursuant to USERRA will be counted concurrently with your maximum COBRA continuation coverage period.

NOTE: Participants and their dependents may be eligible for coverage under CHAMPUS, a federal health care plan. The Participants should review these coverage's before making a decision to self-pay.

Participants must notify the Plan Office of their return from active duty. The Plan Office will restore the Participant's frozen hours, and the Participant will once again be eligible for all benefits that he/she would normally have been eligible for had he/she not been called to active duty.

However, you may elect to waive your rights under federal law. In that case, your Reserve Account may be applied to provide coverage for your dependents at the applicable rate for active members. The months of coverage so applied would no longer be available to provide coverage upon your return to covered employment.

G. HMO ENROLLEES.

If you or your spouse or dependent have USERRA continuation coverage through the Trust's HMO programs and you are terminated from the program because you move out of the HMO's service area before the applicable USERRA period expires and the Trust does not have a contract with your HMO in that area, you or your spouse or dependent will be allowed to enroll in the Group Medical Plan until the expiration of the applicable USERRA period, so long as payment of USERRA premiums are continuous and timely and the other USERRA requirements are met for the continuation of health coverage. Please call the Plan Office for additional details.

H. COVID-19 Impact on Covered Employment (TEMPORARY CONTINUED COVERAGE).

Effective as of March 16, 2020, a Participant is eligible for continued coverage under the Plan for the period of such unemployment only through December hours for February 28, 2021 coverage or when the participant returns to covered employment, whichever occurs earlier, only if the following requirements are met:

(a) worked in Covered Employment or was on the out-of-work list during February 2020 through December 31, 2020 and who loses coverage under the Plan because of lack of covered employment on account of impacts of the COVID-19;
(b) his/her hour bank is already depleted; and
(c) has to be an involuntary unemployment and the person cannot have worked in non-covered employment for a non-signatory employer.

Moreover, if a Participant tests positive for the Coronavirus, resulting in continued absence from covered employment, his or her coverage will be extended without a self-payment if the person's hour bank has been depleted. (Please note if your hour banks are not depleted you would not qualify for the continued coverage). This rule is only applicable through February 28, 2021 coverage.

As the impact of the COVID-19 pandemic is ever changing and given the financial impact to the Plan, this means that after February 28, 2021 the Board of Trustees and/or its delegate may or may not decide whether or not to extend this continued coverage based on the circumstances at that time. **This provision has expired and no longer applies.**

V. TERMINATION OF COVERAGE

Except as provided under the Self Payments provision, an employee and his/her dependents that has been eligible for the benefits of this Plan shall cease to be eligible for the benefits on the earliest date of:

A. EMPLOYEE.

Employee coverage will terminate on the earlier of:

1. The date the person is no longer eligible under the Plan because they have less than 120 hours in their reserve account.
2. The date of termination of the Plan or, if any benefit of the Plan is terminated, on the date of termination of such benefit.

B. DEPENDENT.

Your Dependent coverage will terminate on the earlier of:

1. The date the person ceases to be a dependent as defined in the Plan.
2. The date that the Participant who has Covered Dependents ceases to be eligible under the Plan.
3. The date of termination of the Plan, or if any dependent's benefit of the Plan is terminated, the date of termination of such dependent's benefits.

Under certain conditions, your Dependent's Medical expense coverage may be continued after the date it would terminate. See the Continuation of Coverage provisions described on page 31 under COBRA provisions.

NOTE: When both Federally and State-required continuation is available to you and/or your Dependents, a choice must be made. Thus, the advantages and disadvantages of Federal vs. State continuation should be carefully weighed before either is chosen.

C. LEAVING COVERED EMPLOYMENT/ REINSTATEMENT OF ELIGIBILITY.

Upon leaving Covered Employment a person having reserve hours to their credit in the Plan will have the following options:

1. Running out their reserve hours, or
2. Serving notice to the plan Office within 30 days of leaving Covered Employment of their desire to freeze their reserve hours for a period not to exceed one (1) year.
3. The freezing of reserve hours will be effective on the first day of the calendar month beginning subsequent to the date of serving said notice, provided said notice is received by the Administrator prior to the 15th of the month; if received after the 15th of the month, the freezing will become effective on the first day of the second (2nd) following calendar month.

Upon re-entry into Covered Employment within the one-year period from the date of serving above notice, a person shall be allowed 30 days within which to file notice of their intention to use their reserve hours. The notice should be in writing and sent to the Plan Office.

VI. MEDICAL BENEFITS—ANTHEM BLUE CROSS PPO NETWORK

A. OPEN ENROLLMENT PROCESS.

There is an annual open enrollment period, April 15th to May 15th for new coverage as of June. If the annual enrollment date changes you will be notified. The Plan provides two medical care options and allows an eligible participant to change their health plan selection during open enrollment.

- **The first is a Self-Funded PPO Medical Plan. Anthem/Blue Cross provides the PPO Network.** The Group Number is 277955M001. The phone number is 408-288-4400. Blue Cross can be reached at 800-688-3828.
- **The second option is the Kaiser HMO Medical Plan.** Please refer to Article VII of this Plan booklet for more information on enrolling in the Kaiser HMO option. If you are interested in Kaiser Health Plan coverage and wish to receive a Kaiser packet, please contact the Plan office at 408-288-4433 or 877-827-4239.

B. SUMMARY OF ANTHEM/BLUE CROSS PPO MEDICAL PLAN BENEFITS.

ACTIVE PPO MEDICAL PLAN		
	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK
Deductible Individual	**None**	**$250**
Deductible Family	**None**	**$500**
Annual Out-of-Pocket Maximum	**The out-of-pocket maximum is $1,250 per individual and $2,500 per family Deductible and office visits copayments do not apply to the out-of-pocket maximum. ***	**The out-of-pocket maximum is $2,000 per individual and $4,000 per family Deductible and office visits copayments do not apply to the out-of-pocket maximum. ***
LIFETIME MAXIMUM	**There is no lifetime maximum**	**There is no Lifetime maximum**

ANNUAL MAXIMUM	There is no Annual maximum	There is no Annual maximum
	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES
Physician Services		
Office visits	$15 COPAYMENT	$15 COPAYMENT
Hospital/Skilled Nursing visits	90%	60% after deductible
Specialists	$15 COPAYMENT	$15 COPAYMENT
Surgeon/Asst. Surgeon	90%	60% after deductible
Anesthesiologist	90%	60% after deductible
Diagnostic X-ray & Labs	90%	60% after deductible
See Article J. 31 for definition		
Preventive Care		
Routine Physical Exam	100% (Effective 6/1/2016)	60% after deductible
Well Baby Care	Covered from birth to age 3	60% after deductible Covered from birth to age 3
Immunizations	Covered from birth to age 3	60% after deductible Covered from birth to age 3
Hospital/Surgical Services		
Inpatient	90%	60% after deductible except for No Surprise Act covered services same as in-network cost-sharing
Outpatient	90%	60% after deductible except for No Surprise Act covered services same as in-network cost-sharing
Emergency Services		
Ambulance	90%	90% after deductible except Air Ambulance covered same as in-network cost-sharing
Emergency Room	90% after $50 copay, waived if admitted	90% after $50 copay, copay & deduc. waived if admitted
Maternity Services		
Hospital Benefits – Delivery	90%	60% after deductible except No Surprise Act covered services same as in-network cost sharing
Outpatient Physician Services	90%	60% after deductible
Surgical Services	90%	60% after deductible except No Surprise Act covered services same as in-network cost sharing
	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES
Prescription Drugs Generic or Brand Retail Purchase	Prescription Drugs are provided by SAV Rx-Care $5 Generic/$15 Preferred Brand/ $25 Non-Preferred Brand 30-day supply	Prescription Drugs are provided by SAV Rx-Care 100% less reimbursement to network pharmacy 30-day supply
Mail Order Generic or Brand	$10 Generic & $30 Preferred Brand/ $50 No Preferred Brand 90-day supply	100% less reimbursement to network pharmacy 90-day supply
Chiropractic Services	90% **	60% after deductible **
Continued Care Services		
Home Health Care	90%	60% after deductible**
Skilled Nursing Facility	Following discharge from an acute care facility, plan pays 90%	Following discharge from an acute care facility, plan pays 60%
Physical Therapy	90% ** (30 visit limit)	60% after deductible ** (30 visit limit)
Speech Therapy	90% **	60% after deductible **
Nutritional Counseling	90% (30 visit limit per calendar year)	60% after deductible (30 visit limit per calendar year)

** Note: There is a 30 visit per calendar year limit for services. (90% or 60% cost-sharing is what the Plan Pays.)

EARLY RETIREE PPO MEDICAL PLAN

	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK
Deductible Individual	None	$250
Deductible Family	None	$500

Other Deductible	$100 for retail prescription drug expenses	$100 for retail prescription drug expenses
Annual Out-of-Pocket Maximum	The out-of-pocket maximum is $1,500 per individual and $3,000 per family Deductible and office visits copayments do not apply to the out-of-pocket maximum. *	The out-of-pocket maximum is $4,500 per individual and $9,000 per family Deductible and office visits copayments do not apply to the out-of-pocket maximum. *
LIFETIME MAXIMUM	There is no lifetime maximum	There is no Lifetime maximum
ANNUAL MAXIMUM	There is no Annual maximum	There is no Annual maximum
	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES
Physician Services		
Office visits	$15 COPAYMENT	$15 COPAYMENT
Hospital/Skilled Nursing visits	80%	60% after deductible
Specialists	$15 COPAYMENT	$15 COPAYMENT
Surgeon/Asst. Surgeon	80%	60% after deductible
Anesthesiologist	80%	60% after deductible
Diagnostic X-ray & Labs	80%	60% after deductible
See Article J. 31 for definition		
Preventive Care		
Routine Physical Exam	100% (Effective 6/1/2016)	60% after deductible
Well Baby Care	Covered from birth to age 3	60% after deductible Covered from birth to age 3
Immunizations	Covered from birth to age 3	60% after deductible Covered from birth to age 3
Hospital/Surgical Services		
Inpatient	80%	60% after deductible except No Surprise Act covered services same as in-network cost sharing
Outpatient	80%	60% after deductible except No Surprise Act covered services same as in-network cost sharing
Emergency Services		
Ambulance	80%	60% after deductible except Air Ambulance covered same as in-network cost sharing
Emergency Room	80% after $50 copay, waived if admitted	80% after $50 copay, copay & deduc. waived if admitted
Maternity Services		
Hospital Benefits – Delivery	80%	60% after deductible except No Surprise Act covered services same as in-network cost sharing
Outpatient Physician Services	80%	60% after deductible
Surgical Services	80%	60% after deductible except No Surprise Act covered services same as in-network cost sharing
	BENEFITS FOR COVERED SERVICES	BENEFITS FOR COVERED SERVICES
Prescription Drugs Generic or Brand Retail Purchase	Prescription Drugs are provided by SAV Rx-Care $5 Generic/$15 Preferred Brand/ $25 Non-Preferred Brand 30-day supply	Prescription Drugs are provided by SAV Rx-Care % less reimbursement to network pharmacy 30-day supply
Mail Order Generic or Brand	$10 Generic & $30 Preferred Brand/ $50 No Preferred Brand 90-day supply	100% less reimbursement to network pharmacy 90-day supply
Chiropractic Services	80% **	60% after deductible **
Continued Care Services		
Home Health Care	80% **	60% after deductible**
Skilled Nursing Facility	Following discharge from an acute care facility, plan pays 80%	Following discharge from an acute care facility, plan pays 60%
Physical Therapy	80% **	60% after deductible **
Speech Therapy	80% **	60% after deductible **
Nutritional Counseling	80% (30 visit limit per calendar year)	60% after deductible (20 visit limit per calendar year)

** Note: There is a 20 visit per calendar year limit for services. (80% or 60% cost-sharing is what the Plan Pays.)

APPRENTICE PPO MEDICAL PLAN

	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK
Deductible Individual	**None**	**$500**
Deductible Family	**None**	**$1,000**
Annual Out-of-Pocket Maximum	**The out-of-pocket maximum is $1,250 per individual and $2,500 per family Deductible and office visits copayments do not apply to the out-of-pocket maximum. ***	**The out-of-pocket maximum is $4,500 per individual and $9,000 per family Deductible and office visits copayments do not apply to the out-of-pocket maximum. ***
LIFETIME MAXIMUM	**There is no lifetime maximum**	**There is no Lifetime maximum**
ANNUAL MAXIMUM	**There is no Annual maximum**	**There is no Annual maximum**
	BENEFITS FOR COVERED SERVICES	**BENEFITS FOR COVERED SERVICES**
Physician Services		
Office visits	**$20 COPAYMENT**	**$20 COPAYMENT**
Hospital/Skilled Nursing visits	**90%**	**60% after deductible**
Specialists	**$20 COPAYMENT**	**$20 COPAYMENT**
Surgeon/Asst. Surgeon	**90%**	**60% after deductible**
Anesthesiologist	**90%**	**60% after deductible**
Diagnostic X-ray & Labs	**90%**	**60% after deductible**
See Article J. 31 for definition		
Preventive Care		
Routine Physical Exam	**100% (Effective 6/1/2016)**	**60% after deductible**
Well Baby Care	**Covered from birth to age 3**	**60% after deductible Covered from birth to age 3**
Immunizations	**Covered from birth to age 3**	**60% after deductible Covered from birth to age 3**
Hospital/Surgical Services		
Inpatient	**90%**	**60% after deductible except No Surprise Act covered services same as in-network cost sharing**
Outpatient	**90%**	**60% after deductible except No Surprise Act covered services same as in-network cost sharing**
Emergency Services		
Ambulance	**90%**	**90% after deductible except Air Ambulance covered same as in-network cost sharing**
Emergency Room	**90% after $50 copay, waived if admitted**	**90% after $50 copay, copay & deduc. waived if admitted**
Maternity Services		
Hospital Benefits – Delivery	**90%**	**60% after deductible except No Surprise Act covered services same as in-network cost sharing**
Outpatient Physician Services	**90%**	**60% after deductible**
Surgical Services	**90%**	**60% after deductible except No Surprise Act covered services same as in-network cost sharing**
	BENEFITS FOR COVERED SERVICES	**BENEFITS FOR COVERED SERVICES**
Prescription Drugs Generic or Brand Retail Purchase	**Prescription Drugs are provided by SAV Rx-Care $10 Generic/$25 Preferred Brand/ $40 Non-Preferred Brand 30-day supply**	**Prescription Drugs are provided by SAV Rx-Care 100% less reimbursement to network pharmacy 30-day supply**
Mail Order Generic or Brand	**$20 Generic & $50 Preferred Brand/ $80 No Preferred Brand 90-day supply**	**100% less reimbursement to network pharmacy 90-day supply**
Chiropractic Services	**90% ****	**60% after deductible ****
Continued Care Services		
Home Health Care	**90%**	**60% after deductible****
Skilled Nursing Facility	**Following discharge from an acute care facility, plan pays 90%**	**Following discharge from an acute care facility, plan pays 60%**
Physical Therapy	**90% ****	**60% after deductible ****
Speech Therapy	**90% ****	**60% after deductible ****
Nutritional Counseling	**90% (30 visit limit per calendar year)**	**60% after deductible (30 visit limit per calendar year)**

** Note: There is a 30 visit per calendar year limit for services. (90% or 60% cost-sharing is what the Plan Pays.

PRE-APPRENTICE PPO MEDICAL PLAN

	LEVEL ONE PPO PROVIDERS	LEVEL TWO OUT OF NETWORK
Deductible Individual	**$250**	**$500**
Deductible Family	**$750**	**$1,000**
Annual Out-of-Pocket Maximum	**The out-of-pocket maximum is $1,250 per individual and $2,500 per family Deductible and office visits copayments do not apply to the out-of-pocket maximum. ***	**The out-of-pocket maximum is $4,500 per individual and $9,000 per family Deductible and office visits copayments do not apply to the out-of-pocket maximum. ***
LIFETIME MAXIMUM	**There is no lifetime maximum**	**There is no Lifetime maximum**
ANNUAL MAXIMUM	**There is no Annual maximum**	**There is no Annual maximum**
	BENEFITS FOR COVERED SERVICES	**BENEFITS FOR COVERED SERVICES**
Physician Services		
Office visits	**$20 COPAYMENT**	**$20 COPAYMENT**
Hospital/Skilled Nursing visits	**85%**	**60% after deductible**
Specialists	**$20 COPAYMENT**	**$20 COPAYMENT**
Surgeon/Asst. Surgeon	**85%**	**60% after deductible**
Anesthesiologist	**85%**	**60% after deductible**
Diagnostic X-ray & Labs	**85%**	**60% after deductible**
See Article J. 31 for definition		
Preventive Care		
Routine Physical Exam	**100% (Effective 6/1/2016)**	**60% after deductible**
Well Baby Care	**Covered from birth to age 3**	**60% after deductible Covered from birth to age 3**
Immunizations	**Covered from birth to age 3**	**60% after deductible Covered from birth to age 3**
Hospital/Surgical Services		
Inpatient	**85%**	**60% after deductible except No Surprise Act covered services same as in-network cost sharing**
Outpatient	**85%**	**60% after deductible except No Surprise Act covered services same as in-network cost sharing**
Emergency Services		
Ambulance	**85%**	**90% after deductible except Air Ambulance covered same as in-network cost sharing**
Emergency Room	**85% after $100 copay, waived if admitted**	**85% after $100 copay, copay & deduc. waived if admitted**
Maternity Services		
Hospital Benefits – Delivery	**85%**	**60% after deductible except No Surprise Act covered services same as in-network cost sharing**
Outpatient Physician Services	**85%**	**60% after deductible**
Surgical Services	**85%**	**60% after deductible except No Surprise Act covered services same as in-network cost sharing**
	BENEFITS FOR COVERED SERVICES	**BENEFITS FOR COVERED SERVICES**
Prescription Drugs Generic or Brand Retail Purchase	**Prescription Drugs are provided by SAV Rx-Care $20 Generic/$40 Preferred Brand/ $80 Non-Preferred Brand 30-day supply**	**Prescription Drugs are provided by SAV Rx-Care 100% less reimbursement to network pharmacy 30-day supply**
Mail Order Generic or Brand	**$40 Generic & $80 Preferred Brand/ $160 No Preferred Brand 90-day supply**	**100% less reimbursement to network pharmacy 90-day supply**
Chiropractic Services	**85% ****	**60% after deductible ****
Continued Care Services		
Home Health Care	**85%****	**60% after deductible****
Skilled Nursing Facility	**Following discharge from an acute care facility, plan pays 85%**	**Following discharge from an acute care facility, plan pays 60%**
Physical Therapy	**85% ****	**60% after deductible ****
Speech Therapy	**85% ****	**60% after deductible ****
Nutritional Counseling	**85%****	**60% after deductible ****

** Note: There is a 20 visit per calendar year limit for services. (85% or 60% cost-sharing is what the Plan Pays.)

C. SELF-FUNDED PLAN.

This Section highlights the benefits including coverage requirements provided under your Self-Funded Anthem Blue Cross PPO Medical Plan. The purpose is to give you quick access to the information you will most often want to review.

The Plan allows the option of obtaining treatment from a Prudent Buyer Network Provider (PPO) or a provider who does not participate in the Prudent Buyer Network. All claims, payments, and questions are handled by United Administrative Services (UAS), the claims administrator.

The Plan allows you to seek care from any doctor, medical group, or hospital, but the benefits you receive will be considerably lower if you do not use a Prudent Network Buyer Provider, which means that your out-of-pocket expense will be higher. You may access coverage under any one of two levels of coverage, in-network and out-of-network. The applicable deductibles and out-of-pocket amounts will be applied depending which provider you utilize.

You may obtain treatment from any Prudent Buyer Network Provider, participating doctor, or hospital anywhere in California. To you, this means that these doctors and hospitals have agreed to accept the Prudent Network Buyer allowances as full payment for covered services.

D. COVERAGE.

The PPO Medical Plan includes comprehensive coverage for hospitalization, outpatient treatment, diagnostic laboratory and x-ray services, and prescription medication, as explained in this Summary Plan Description. You have the option of obtaining treatment from a PPO provider or out-of-network (Non-PPO) Provider.

1. Level One – In-Network PPO Provider: The plan pays an amount equal to the Prudent Buyer allowance depending upon which the provider is utilized for medical treatment received, subject to the deductible and co-payments. Refer to the Schedule of Benefits for deductible, co-payment and maximums. The Prudent Buyer allowance is the dollar amount paid for each particular type of medical service set by the Prudent Buyer Network. Prudent Buyer Providers have agreed to accept the PPO allowance as full payment for covered services for Prudent Buyer members, although they will often list a higher fee.

2. Level Two - Out-of-Network, Non-PPO Provider: This level allows you to seek medical coverage from any medical provider outside of the Prudent Buyer Network, but the benefits you will receive are considerably lower. The amount allowed for Non-PPO Providers is based on the Usual, Customary and Reasonable (UCR) Charge. **(Please see Definitions in Article VI., Section I.)** The out of network provider will be reimbursed at 60% of UCR. You will be responsible for any amount the provider charges which is in excess of UCR**.**

However, effective June 1, 2022, the following No Surprise Act covered items and services for: (a) Non-PPO Provider Emergency Services, (b) non-Emergency services provided by a Non-Contract Provider at a Contract facility, and (c) Air Ambulance Services are not subject to the UCR Charge and instead will be based on the "Recognized Amount." Recognized Amount means (in order of priority) one of the following:

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

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

(iii) The lesser of the billed amount charged by the provider or facility or the Qualifying Payment Amount.

For Air Ambulance Services furnished by non-Contract providers, Recognized Amount is the lesser of the amount billed by the provider or facility or the Qualifying Payment Amount. **(Please see Definitions in Article VI, Section J Below.)**

Any additional limits on the number of visits or days covered are stated under the specific benefit.

E. CHOICE OF PROVIDERS.

The Plan covers treatment provided by a physician or surgeon, licensed to prescribe and administer all drugs and to perform all surgery deemed necessary by a licensed physician or surgeon. As a Prudent Buyer member, you will enjoy significant savings by using a Prudent Buyer Network PPO provider. These providers have agreed to accept the Prudent Buyer allowance as payment in full. In utilizing non-Prudent Buyer providers, you will be responsible for any additional charges in excess of the Prudent Buyer allowance.

Before using a network doctor or hospital, you should always inquire if the Network provider is a Prudent Buyer member. To verify if your doctor is a Prudent Buyer member, you may contact United Administrative Services at 408-288-4400, or Blue Cross at 1-800-688-3828 or on-line at **www.anthem.com/ca/**

If your physician refers you to a specialist, you should request a referral to a Prudent Buyer member. This is particularly important for anesthesiologists, radiologists, and for any diagnostic testing.

F. AVOID PHYSICIAN OVER-CHARGES FROM PRUDENT BUYER PROVIDERS.

Upon visiting a Prudent Buyer Network Provider, the doctor's office will bill for all expenses and payment will be sent directly to the doctor. You will receive an Explanation of Benefits (EOB) form for each claim. This form will show the amount of the claim(s) and how much will be paid to the doctor under the Prudent Buyer Network allowance. The EOB form will tell you how much you pay to the doctor.

Should you receive a bill from a Prudent Buyer Network Provider for more than the Prudent Buyer Network allowance shown on the EOB, you should send the doctor a photocopy of the statement showing the maximum allowance, with a note reminding the doctor they are a Prudent Buyer Network member. You are not required to pay any balance exceeding the Prudent Buyer Network allowance when treated by a member PPO doctor. For questions regarding a claim, or bills you receive from a provider that are in excess of the Prudent Buyer Network Fee, call United Administrative Services at (408) 288-4400.

G. SUMMARY OF BENEFIT LEVELS.

When you receive care from a Prudent Buyer Network Provider, you assure yourself of the highest possible benefit. You also save the plan money and help keep medical premiums down, thereby enabling the Trust Fund to maintain a high level of employee health benefits.

1. Level One - In-Network: The deductible and the out-of-pocket maximum is the lowest for this level of coverage. If you choose a Prudent Buyer Network Provider to receive services, you will receive the highest level of benefits. Prudent Buyer Network Providers offer a substantial discount, which provides the greatest benefits. The deductible is $250 per individual or $500 per family per calendar year and the plan pays 90% of covered expenses until the out-of-pocket amount reaches $1,000 for an individual and $2,000 per family and then 100% thereafter each calendar year. Physician charges for an office visit require a co-pay amount for

each office visit. **The office visit co- pay amount does not apply to the annual deductible or the out-of-pocket maximum.**

2. **Level Two - Out-of-Network:** This level allows you to seek medical coverage from any medical provider outside of the Prudent Buyer Network, but the benefits you will receive are considerably lower. Your out-of-pocket expense is considerably increased if you choose Level Two benefits. The deductible is $250 per individual or $500 per family per calendar year and the plan pays 60% of covered expenses at the UCR eligible fee until the out-of-pocket amount reaches $2,000 for an individual and $4,000 per family and then 100% thereafter each calendar year. Physician charges for an office visit require a co-pay amount for each office visit. The office visit co-pay amount does not apply to the annual deductible or the out-of-pocket maximum. **Effective June 1, 2022, the following No Surprise Act covered items and services for: (a) Non-PPO Provider Emergency Services, (b) non-Emergency services provided by a Non-Contract Provider at a Contract facility, and (c) Air Ambulance Services will be covered at the same cost-sharing as if received in-network for those covered items and services.**

H. MEDICALLY NECESSARY STANDARDS.

The PPO Medical Plan provides that treatment, supply, or service must be medically necessary and be covered by your program. United Administrative Services (the Plan Administrator) has responsibility for determining whether claims are payable. A practicing physician-consultant retained by the claims administrator must agree if the denial is based on lack of medical necessity. The definition of "**medically necessary**" means a procedure, service, treatment, drug, medicine or supply that a hospital, licensed physician, or other qualified medical practitioner, would provide to a patient for the purpose of preventing, diagnosing, or treating an illness, injury, condition, disease, or its symptoms that meets generally accepted standards of medical and mental health/substance abuse standards of medicine. The mere fact that your doctor orders the treatment does not mean that it is medically necessary. The fact that a provider may prescribe, order, recommend or approve a service or supply does not, of itself, make the service or supply medically necessary. Any final review will be based on professional medical opinion.

Medical Necessity also applies to the type of facility in which you receive care. The Plan does not consider hospitalization medically necessary if the care could be adequately provided in a less expensive facility such as skilled nursing facility or outpatient clinic.

No benefits are payable for care, treatment, services and supplies:

1. to the extent that they are not reasonably necessary for treatment of an injury or disease or to the extent that the charges for care, treatment, services or supplies are unreasonable; or
2. Are Experimental or Investigative.

I. USUAL CUSTOMARY AND REASONABLE (UCR).

1. For providers who are Participants in the Plan's Preferred Provider Organization ("PPO"), UCR means the agreed Prudent Buyer Allowance for the service or supply.

2. For other non-PPO providers, UCR means the table of covered fees provided by Inge nix in effect at the time of the claim, but in no event shall any amount be paid unless:

a. It is within the range of fees which are usually charged and received for the given treatment by doctors of similar training within the appropriate geographic Area;

b. It is customarily charged by the provider for the services or supplies rendered, or if higher than the customary fee, it is justifiable due to a level of treatment which is superior to that customarily provided; and

3. It is reasonable in light of all circumstances.

J. COVERED EXPENSES.

1. **Hospital.** Charges of a hospital for services and supplies rendered during confinement except that charges for room and board shall not exceed the hospital's semi-private room rate; charges of a hospital for confinement in an intensive care unit, contagion ward, isolation or private accommodation, when such confinement is certified by the attending physician as being medically necessary by reason of the severity of the insured person's condition.

2. **Certain Costs Associated with Hospital Care.** Other Inpatient Hospital Care, subject to any limitations specified in the Schedule of Benefits, benefits include the use of operating rooms, delivery rooms, nurseries, recovery rooms, equipment therein and also the following:

A. Oxygen and carbon dioxide, including equipment and administration thereof.

B. Intravenous injection and solutions, such as glucose and serum.

C. Prescription drugs and biologicals.

D. Whole blood and blood derivatives, and administration and processing of same by the hospital, but not including blood procurement charges or charges for maintenance of a blood bank.

E. Dressings, splints, and casts, but not including special braces.

F. Diagnostic services; the following procedures to diagnose a condition, in response to specific symptoms, ordered or performed by a physician or other Licensed Health Care Professional licensed to render the services:

1. Radiology, ultrasound and nuclear medicine services.
2. Laboratory and pathology services.
3. Electrocardiogram, electroencephalogram, ultrasound and other diagnostic procedures.

G. Anesthesia, including continuous epidural anesthesia when used for control of chronic, intractable pain due to terminal cancer or when used for control of acute post-operative pain following select procedures. Anesthesia services are not available in connection with care which is not a Benefit.

3. **Emergency Services.** Effective June 1, 2022, emergency means a medical condition, including mental health condition or substance use disorder, manifesting itself by acute symptoms of sufficient severity including severe pain so that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in a condition described in clause (I), (ii) or (iii) of section 1867(e)(1)(A) of the Social Security Act (42 U.S.C. 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 women or her unborn child in serious jeopardy; clause (ii) which refers to serious impairment to bodily functions and clause (iii) refers to serious dysfunction of any bodily organ or part.)

Emergency services includes medical screening, ancillary services, pre-stabilization services, treatment to stabilize an individual, post stabilization services, surgical procedure, accidental injuries and medical emergencies (shock, acute poisoning, hemorrhaging, etc.) will be covered:

(ii) without prior authorization regardless of whether received in-network or out-of-network;

(iii) without conditions such as denials based on final diagnosis codes,

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

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

(vi) any cost-sharing for out-of-network emergency items and services will not be greater than the in-network cost sharing amount and will count towards the Plan's applicable deductible and out-of-pocket maximums as if the items and services were provided by a participating provider or participating emergency facility.

Effective January 1, 2022, the emergency department of a hospital also includes an independent freestanding emergency department (meaning a health care facility that is geographically separate from a hospital under applicable state law and provides emergency services). Emergency room treatment that is not considered a medical emergency will require a $50.00 co-payment. The co-pay will be waived if the treatment is considered a medical emergency and the patient is admitted to the hospital.

4. Ambulatory Surgical Center.

5. Radiation therapy, chemotherapy and hemodialysis treatment.

6. Skilled Nursing Facility or Rehabilitation Facility Treatment.

A. For confinement in a skilled nursing or rehabilitation facility which immediately follows at least three days of hospital confinement includes ambulance service for transfer from hospital. Charges of a hospital for services and supplies rendered during confinement except that charges for room and board shall not exceed the hospital's semi-private room rate.

B. The services must be consistent with the illness, injury, degree of disability and medical needs of the patient. Benefits are only provided for the number of days required to treat the member's illness or injury. Services must be those which are regularly provided and billed by a Skilled Nursing Facility.

C. The patient must remain under the active medical supervision of a Physician. The Physician must be treating the illness or injury for which the patient is confined in the Skilled Nursing Facility.

7. Surgeon's Charges by a Physician for the performance of surgical procedures.

8. Anesthesia Charges and its administration when these are not covered as Hospital charges.

9. Physician's Charges for medical care and treatment including:

A. Emergency room visits at hospital or clinics.

B. Inpatient hospital visits during a covered inpatient stay (except those relating to surgery), limited to one a day unless additional visits are needed due to the member's medical condition.

C. Extra time spent when the physician is detained to treat a member in critical condition that requires constant care.

D. Services of a physician at his office or in your home for treatment of illness or disease.

10. Nursing, Physiotherapy, and Occupational Therapy Charges for:

A. Private duty nursing care by a Nurse;

B. Treatment by a licensed physiotherapist; and

C. Treatment by a licensed occupational therapist.

The person providing the care must not live with or be related to the Insured Person or to his or her spouse.

11. Radiological and Laboratory Charges for diagnostic purposes and preventive screening tests that the physician determines to be medically necessary based on family medical history:

A. X-rays;

B. Radiological treatment;

C. Diagnostic laboratory tests;

D. Low-dose mammography screening;

E. Annual cervical cancer screening test (Pap smear); and

F. Endoscopy, arthroscopy and colonoscopy.

12. Cosmetic Surgery and related charges are covered only:

A. As a result of an injury sustained while insured under this plan;

B. For replacement of diseased tissue surgically removed;
C. For the initial reconstruction of a breast after a mastectomy; and

A. Repair of bodily damage covered by disease and/or radiation treatment.

13. Women's Health and Cancer Rights Act of 1998:

The Plan covers medical and surgical benefits for mastectomies. This coverage includes:

A. reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction, nipple and areola repigmentation to restore the physical appearance of the breast, as a required stage of reconstruction);

B. surgery and reconstruction of the other breast to produce symmetrical appearance;

C. coverage for prosthesis and physical complications of all stages of mastectomy, including lymphedemas, in a manner determined in consultation between you and your attending physician.

The coverage is subject to the Plan's annual deductibles and coinsurance provisions. For more information, please call either Kaiser if you are enrolled in the Kaiser HMO plan or the Trust Fund Office if you are enrolled in the self-funded PPO option.

14. <u>Ambulance and Air Ambulance are allowed at the prevailing usual, customary and reasonable charges and subject to the following</u>:

A. Professional ambulance service when used to transport the insured person directly from the place where he/she is injured or becomes ill to the hospital(s) where treatment is given.

B. Professional ambulance service when also used to transport insured member from general hospital or emergency room to hospitals of specialty treatment, or to home hospital area.

C. Effective June 1, 2022, Transportation by Air Ambulance (includes both in-network and out-of-network) from one hospital to another will be allowed when certified by the attending physician as being medically necessary by reason of the severity of the insured person's condition and to avoid the possibility of serious complications or loss of life. This also includes transportation to the United States from a foreign country. **Effective June 1, 2022, any cost-sharing for Out-of-network Air Ambulance services will not be greater than the in-network cost sharing amount and will count towards the Plan's applicable deductible and out-of-pocket maximums as if the items and services were provided by a participating provider. The new balance billing protections do not apply to ground ambulance bills.**

D. Services must be provided by a Licensed Air Ambulance **(effective June 1, 2022 meaning medical transport by a rotary-wing air ambulance or fixed-wing air ambulance including inter-facility transports)**, a licensed ambulance company, by professional non-air ambulance or on a regularly scheduled flight on a commercial airline when:

1. Special and unique Covered Hospital Services are required which are not provided by a local Hospital;
2. Transportation is medically necessary as deemed by the Administrator; and
3. Transportation is to the nearest Hospital equipped to furnish the services.

E. Base charge, mileage and non-reusable supplies of a licensed ambulance or ambulance company.

F. Monitoring, electrocardiograms (EKG'S or ECG'S), cardiac defibrillation, cardio-pulmonary resuscitation (CPR) and administration of oxygen and intravenous (IV) solutions in connection with ambulance service. An appropriately licensed person must render the services.

15. <u>Home Health Care by approved home health care agency as recommended by physicians does not include custodial care</u>.

16. <u>Physical therapy</u>.

17. Allergy testing, treatments and allergy injections.

18. Dental benefit: inpatient hospital benefits are provided for up to three days during each period of hospital confinement for:

A. Dental surgery or extraction when required under general anesthesia;

B. Treatment to the teeth, gums or their dependent tissues when certified by the attending physician as being medically necessary, because the conditions under treatment are of such nature as to endanger the life of the insured person; and

C. Dental care in accident cases - payment will be made for services incident to the treatment of injuries to the natural teeth, jaws and their dependent tissues customarily performed by dentists and oral surgeons. The services do not include the cost of or services for restoration of function or appearance (dentures, braces, etc.). These are covered by Delta Dental under the Dental plans.

19. Pregnancy and Maternity Care.

Covered expenses for pregnancy and maternity care, including termination of pregnancy for medical reasons are eligible. Elective termination of pregnancy is not covered.

Covered expense for hospital benefits for routine nursery care of a newborn Child, if the Child's natural mother is enrolled under this Agreement and eligible for pregnancy and maternity coverage.

Effective February 1, 2016, charges for pregnancy and related conditions covered under the Plan is extended to eligible Dependent Children.

20. Organ and Tissue Transplants.

Expenses for an organ transplant with such procedures limited to those transplants that are medically necessary and to the extent that they are not deemed experimental or investigative.

Experimental procedures are all procedures not generally provided as treatment by the organized medical community in California, and those that are mainly limited to laboratory and/or animal research.

Investigative procedures are experimental procedures that have progressed to limited use on humans, but which are not widely accepted as proven and effective procedures within the organized medical community in California.

21. Hospice care benefits provided for a terminally ill person within a six (6) month or less life expectancy upon certification of a physician. The following services are covered:

A. Nursing services by or under supervision of a registered nurse;

B. Necessary medical equipment including oxygen;

C. Home health aide; and

D. Counseling.

22. **Artificial limbs or eyes. This includes services of an orthotist and prosthetist in connection with evaluation or the fitting of an orthotic or prosthetic device when those services are billed as part of the charge of the artificial limbs or eyes.**

Provided that benefits shall cover artificial limbs or eyes, only when such devices are:

A. Affixed to the body externally;

B. Required to replace all or any part of any limb or eye;

C. Required to support or correct a defect or form or function of a permanently inoperative or malfunctioning limb or eye.

And further provided benefits do not extend to the repair or replacement of prosthetic devices occasioned by misuse or loss.

23. **Rental or purchase of dialysis equipment**, dialysis supplies and rental or purchase of other medical equipment and supplies, which are:

A. Ordered by a physician;

B. Of no further use when medical need ends;

C. Usable only by the patient;

D. Not primarily for the Member's comfort or hygiene;

E. Not for environmental control;

F. Not for exercise;

G. Manufactured specifically for medical use;

H. Approved as effective, and considered the usual and customary treatment of a condition as determined by the Plan; and

I. Not for prevention purposes.

Rental charges that exceed the reasonable purchase price of the equipment are not covered, as determined by the Administrator.

24. **Prescription Drugs:** Please refer to Section III, Prescription Coverage.

25. **Chiropractic Care** except for vitamin supplements, lumbar supports or pillows or massage therapy or maintenance therapy. Please see limitations on the schedule of benefits.

26. **Routine physical exams** are covered.

27. **Charges for oxygen** and the rental of equipment for the giving of oxygen.

28. **Cancer Clinical Trials**. The plan will reimburse Covered Expenses, for Routine Patient Care Costs in connection with participation in Cancer Clinical Trials as defined below.

A. Cancer Clinical Trials - Definition

Phase 1, Phase II, Phase III and phase IV cancer clinical trials, if all the following conditions are met:

The treatment provided in a clinical trial must either:

1. Involve a drug that is exempt under federal regulations from a new drug application, or

2. Be approved by:

    a) One of the National Institutes of Health;
    b) The Federal Food and Drug Administration in the form of an investigational new drug application;
    c) The United States Department of Defense

B. Routine Patient Care Costs – Definition

The costs associated with the provision of services, including drugs, items, devices and services which would otherwise be covered under the Plan, including health care services which are:

1. Typically provided if a clinical trial were not involved.

2. Required solely for the provision of the investigational drug, item, and device of service.

3. Clinically appropriate monitoring the investigational item of service.

4. Used to prevent complications arising from the provision of the investigational drug, item, device or service.

5. Are considered to be reasonable and necessary care arising from the provision of the investigational drug, item, device or service, including the diagnosis or treatment of the complications.

C. Routine Patient Care Costs do not include any of the following:

1. Drugs or devices not approved by the federal Food and Drug Administration that are associated with the Cancer Clinical Trial.

2. Services other than health care services, such as travel, housing, companion expenses and other non-clinical expenses that you may require as a result of the treatment provided for the purposes of the clinical trial.

3. Any item or service provided solely to satisfy data collection and analysis needs not used in the clinical management of the patient.

4. Health care services that, except for the fact they are provided in a clinical trial, are otherwise specifically excluded from the Plan.

5. Health care services customarily provided by the research sponsors free of charge to patients enrolled in the trial.

Additional Provisions

1. The covered Person must be diagnosed with cancer for Routine Patient Care Costs to be eligible for this benefit.

2. Participation in Cancer Clinical trials must be recommended by the physician of the Covered Person after determining the Covered Person's participation has a meaningful potential to benefit the Covered Person.

3. The Cancer Clinical Trial must have a therapeutic intent.

4. Cancer Clinical Trials just to test toxicity are not eligible.

29. Essential Health Benefits. Essential Health Benefits means benefits that fall within the categories below as determined by the Plan and Claims Administrator in its sole discretion and subject to the requirements of the Affordable Care Act:

A. Ambulatory patient services.
B. Emergency services.
C. Hospitalization.
D. Maternity and newborn care.
E. Mental Health and Substance Abuse Disorder services, including behavioral health treatment.
F. Prescription drugs.
G. Rehabilitative and habilitative services and devices.
H. Laboratory services.
I. Preventive and wellness services and chronic disease management.
J. Pediatric services, including oral and vision care.

30. Nutritional Counseling. Medically necessary nutritional/diet counseling for participants and dependents at a higher risk for chronic disease, including but not limited to participants and dependents who are overweight or obese and have additional cardiovascular disease (DVD) risk factors, when prescribed by a provider or other qualified licensed health professional recognized under the Plan.

31. Preventive Care Benefits. Effective June 1, 2016, the Plan shall provide in-network preventive care benefits for routine medical examinations (including but not limited to office visits, immunizations and screenings) consistent with the recommendations and guidelines set by the federal government pursuant to the Affordable Care Act, as amended. Benefits will be provided at no charge to participants and dependents, if preventive care services are received within in-network only. There is no change to the Plan's payment for out-of-network preventive care benefits (see the applicable Benefit Comparisons). The Board of Trustees shall interpret this provision consistent with guidance issued by the Department of Health and Human Services and/or the Department of Labor. In general, the Plan will cover all of the preventive services listed in the federal government's recommendations and guidelines (for the latest list of federal government guidelines, see https://www.healthcare.gov/coverage/preventive-care-benefits/) and as follows:

A. Evidence-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 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 of the Center for Disease

Control and Prevention with respect to the individual involved (for this purpose, a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention is considered in effect after it has been adopted by the Director of the Centers for Disease Control and Prevention, and a recommendation is considered to be for routine use if it is listed on the Immunization Schedules of the Centers for Disease Control and Prevention);

C. With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in comprehensive guidelines supported by the Health Resources and Services Administration; and
D. With respect to women, evidence-informed preventive care and screenings provided for in binding comprehensive health plan coverage guidelines supported by the Health Resources and Services Administration, in accordance with 45 C.F.R. 147.131(a).

32. Transgender Services. Procedures or treatments, including but not limited to breast augmentation, tracheal shave, facial feminization surgery, lipoblast of the waist, rhinoplasty, face lifts, blepharoplasty, voice modification therapy and surgery, hormonal therapy (including prescription drugs for pre-approved off-label indications), for transgender services determined to be medically necessary by a licensed physician will be covered under the Plan. Medically necessary transgender benefits are determined in accordance with the World Professional Association for Transgender Health Standards of Care ("WPATH") along with the terms and conditions of the Plan that apply to all other covered medical and mental health conditions, including medical necessity requirements, utilization management and exclusions. For example, transgender surgery, if medically necessary and meeting the guidelines of the Plan, would be covered on the same basis as any other covered medically necessary surgery. Procedures that are determined not to be medically necessary or are not covered under the Plan rules are excluded. Surgery or prescription drugs related to transgender services are subject to prior authorization in order for coverage to be provided.

33. Mental Health & Substance Abuse Benefits.

(a) The Plan will cover medically necessary treatments for mental health and substance abuse benefits. There is no day nor visit limits to inpatient and outpatient mental health and substance abuse benefits. Beat It! administers substance abuse benefits under the Plan and, the Plan has also contracted with Optum Behavioral Solutions ("Optum") to provide prior authorization for medically necessary mental health/substance abuse services for the self-funded PPO medical plan participants. Optum Network providers are responsible for getting prior authorization for eligible participants for any inpatient or residential care. Optum will also monitor behavioral health service treatment. Any questions about behavioral health benefits should be addressed to Optum Administrative services at (408) 288-4402.

(b) Beat It! (For Substance Abuse Benefits Only). The Plan has contacted with Beat It! to administer the Plan's substance abuse services. Beat It! has an extensive network of carefully selected providers and resources that are knowledgeable, effective and experienced in addressing situations. A full range of treatment facilities, program, counselors and professionals are available to meet your needs. All substance abuse services must be pre-authorized through the Beat It! Beat It! is available to members who have selected the self-funded PPO plan option. Please contact Beat It! at 800-828-3939 for all substance use concerns. The Beat It! network of providers for substance abuse services include:

- Acute Facilities
- Residential Facilities
- Intensive Outpatient Programs (IOP)
- Individual Counselors & Therapists
- Specialized Professionals

(c) Approved Recovery Facilities and Benefit. If you or your eligible dependent uses a Beat It! Approved recovery facility for substance abuse/chemical dependency benefits, the Trust will pay the applicable cost-sharing amount. Note: However, you are responsible for your share of any cost (ex. coinsurance amount).

There are no annual or lifetime limits-imposed substance abuse benefits. Please contact the Trust Fund Office for the most current cost-sharing amount. If you do not use a Beat It! approved recovery facility, there is no benefit available under the plan.

34. Coronavirus (COVID-19) Coverage During Public Health Emergency.

A. COVID-19 Testing, Diagnostic Services or Items Coverage. Effective for services or items received on or after March 18, 2020 and during the public health emergency period, the Plan's self-insured coverage through Anthem Blue Cross will cover charges for the following only tests to detect the SARS-COV-2 or COVID-19 of the virus that causes COVID-19 (including serological tests a.k.a antibody tests for COVID-19 used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-COV-2, the virus which causes COVID-19) at no cost (meaning no copayment, deductible or coinsurance) for:

(a) tests approved, cleared or authorized by the FDA,
(b) a test that a test developer intends or has requested FDA authorization for emergency use,
(c) a state authorized test and the state has notified the Department of Health and Human Services, and
(d) other tests that the Secretary of Health and Human Services determines appropriate in guidance, developed during the COVID-19 public health emergency period.

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

Pricing of Out-of-Network Diagnostic Testing. Pursuant to Section 3202 of the CARES Act and subject to any further government regulation and guidance, the Plan or Insurer will pay or reimburse for covered COVID-19 diagnostic tests as follows: (a) an existing negotiated rate if there is one or (b) in the absence of a pre-existing negotiated rate, the cash price listed by the diagnostic test provider on the public internet website of such provider.

Coverage of Over-the-Counter ("OTC") COVID-19 Tests. Effective for purchases on or after January 15, 2022 and during the public health emergency period, the Plan's self-insured coverage through Anthem Blue Cross will provide coverage for, including reimbursement of, all OTC tests (also known as at-home tests or self-tests): (a) approved, cleared or authorized by the FDA, (b) test that received FDA authorization for emergency use, (c) state authorized test and state has notified the Dept. of HHS, and (d) other tests that the Secretary of HHS determined appropriate in guidance during the public health emergency period, to detect the SARS-COV-2 (the virus that causes coronavirus disease 2019) or the diagnosis of COVID-19, purchased through pharmacies, retail stores and online retailers, without any cost-sharing, prior authorization or medical management requirements and without a prescription or involvement of a health care provider.

Pursuant to federal guidance, the Plan is permitted (but not mandated) to make quantity and cost limitations under the following Safe Harbors pursuant to FAQ Part 51. If the Safe Harbor requirements are met the Plan is permitted to implement the following limitations:

(a) **Cost Limits (Through Pharmacy Network or Direct Coverage).** The Plan is permitted to limit reimbursement from a non-preferred pharmacy or other retailers to the lesser of: (i) the actual price of the test or (ii) $12 per test, provided that the:

(1) Plan provides access to direct coverage, without cost-sharing (meaning the participant does not pay an upfront cost and instead the plan or its contracted entity pays the preferred pharmacy or retailer directly) of OTC COVID-19 tests through a preferred pharmacy network or other retailers, including direct-to-consumer shipping programs; and

(2) Plan takes reasonable steps to provide adequate access to OTC COVID-19 tests through an adequate number of retail locations (both in-person and on-line locations).

(b) **Quantity Test limit.** The Plan is permitted to limit OTC COVID-19 tests without a prescription or provider involvement, to no less than 8 tests per covered individual (ex. Participant, Dependent Spouse, Dependent Child) per 30-day period or calendar month. In applying the quantity limit of 8, the Plan may count each test separately, even if multiple tests are sold in one package. The Plan is permitted to set more generous limits although not mandated.

If the above Safe Harbor (a) is not met (for example, if there are delays that are significantly longer than the amount of time it takes to receive other items under the Plan's direct-to-consumer shipping program), the Plan must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set limits relating to reimbursement on the amount of OTC COVID-19 tests.

If the above Safe Harbor (b) is not met (for example, OTC COVID-19 test with doctor's note), the plan must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set quantity limits.

To address suspected fraud or abuse the Plan is permitted to require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of the OTC COVID-19 test or require a self-attestation.

Please contact the Trust Fund Office for more information on how to file a claim for reimbursement or any direct coverage arrangements (if applicable).

B. COVID-19 Treatment. Effective March 13, 2020 and extended through April 31, 2021, if a Plan Participant or Dependent is diagnosed with COVID-19, charges for treatment of the COVID-19 will be covered in full (including hospital admission if applicable) if performed with a PPO-network Provider as provided in this Plan (without a co-pay or deductible or coinsurance). Coronavirus treatment received with a non-PPO network Provider will be covered in the same manner and cost-sharing as other medical necessary treatments performed at a non-network Provider pursuant to the Plan terms (Participant pays 20% of the cost after deductible). As the impact of the COVID-19 pandemic is ever changing, the Board of Trustees

and/or its delegates may or may not decide whether or not to extend this coverage based on the circumstances at that time.

C. COVID-19 Vaccination and Preventive Services Coverage. Effective the earlier of January 1, 2021 or 15 business days after the date on which the United States Preventive Services Task Force ("USPSTF") or the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention ("CDC") makes an applicable recommendation relating to qualifying COVID-19 immunizations the Plan, through its medical providers and pharmacy benefit manager, throughout the duration of the COVID-19 public health emergency, will cover approved COVID-19 vaccinations and immunizations. Once it becomes available to the public and subject to future government guidance, COVID-19 vaccinations will be available to all eligible participants and dependents at no cost whether received in-network and out-of-network and without prior authorization at a doctor's office, medical facilities, governmental health facilities, including participating pharmacies through the Sav RX pharmacy benefit manager. Currently, approved COVID-19 vaccinations include Moderna, Pfizer, Johnson & Johnson & Novavax (this list is subject to change).

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

For network providers, reimbursement for administration of the shots will be based on the Plan's agreed upon contracted rate with Anthem Blue Cross (including Sav RX the Plan's pharmacy benefit manager).

For non-network providers (subject to future government guidance), reimbursement for administration of the shots will be based on a reasonable rate such as: (a) an existing negotiated rate if there is one or (b) in the absence of a pre-existing negotiated rate, the cash price listed by the provider on the public internet website of such provider or the Medicare reimbursement rate.

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

D. Telehealth and Telemedicine Coverage. Effective March 18, 2020 and during the period of the declared COVD-19 public health emergency, the self-funded PPO Plan will cover medically necessary services, subject to current Plan provisions relating to reimbursement of in-network and out-of-network providers, the following virtual services provided by a medical practitioner: (a) telehealth/telemedicine visits (a visit between a medical practitioner and a patient via two-way communication), (b) virtual check-in (a brief 5-10 minute check-in with a medical practitioner via telephone or telecommunication to decide whether an office visit is necessary), and (3) e-visits (a communication between a patient and medical practitioner through an online patient portal). The three (3) foregoing services will be performed consistent with guidelines published by the Centers for Medicare & Medicaid Services ("CMS") in order to be covered (FACT SHEET March 17, 2020). To clarify, telehealth/telemedicine coverage does include mental health/substance abuse disorder coverage.

35. **<u>Orthotic Devices.</u>** Medically necessary orthotic devices when ordered by a physician, podiatrist or qualified health care provider will be covered pursuant to the current contracted/negotiated rate for the orthotic device. Reimbursement is allowed for replacement of orthotic devices due to change in participant's condition, irreparable wear, permanent and/or accidental damages or substantial change in growth and/or weight once every twelve (12) months.

36. Non-Emergency Services Provided by Out-of-Network Provider at In-Network Facility.

Effective June 1, 2022, any cost-sharing for medically necessary non-emergency items, services and visits (which may include equipment, devices, telemedicine, imaging services, lab work, preoperative and postoperative services) performed by an out-of-network provider at in-network facilities (for which the participant or dependent has not knowingly and voluntarily provided consent pursuant to the No Surprise act patient consent and notice requirements) will not be greater than the in-network cost sharing amount and will count towards the Plan's applicable deductible and out-of-pocket maximums as if the non-emergency items and services were provided by a participating provider. Non-emergency health care facilities include hospitals, hospital outpatient departments, critical access hospitals and ambulatory surgical centers.

Participants and dependents can knowingly and voluntarily agree to be balance billed including waiving the protections that limit cost-sharing for non-emergency services and post-stabilization services provided the following patient consent and notice requirements under CAA Section 2799B-2(d) are met:

1. Notice and consent must be provided together and be physically separate from any other documents by Provider/Facility;
2. Must be provided at least 72 hours prior to the scheduled appointment, or if same day no later than 3 hours prior to appointment.
3. Notice and consent must list provider's name, good faith estimates for items or services reasonably expected to be provided, statement that patient is not required to consent (and may instead seek care from an available participating provider/facility and in-network cost sharing will apply in such cases), and must be available in 15 most common languages in the geographic region.
4. Copy of signed consent must be provided to patient (via in-person or through mail or email) method selected by patient.

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

1. Emergency services;
2. Air ambulance services;
3. Ancillary services at in-network hospital or ambulatory surgical center, such as emergency medicine, anesthesiology, pathology, radiology, neonatology, assistant surgeon care, hospitalists, intensivists and diagnostic care such as radiology and lab work); and
4. Non-emergency services, if no in-network provider is available or unforeseen urgent medical need or provider furnishes ancillary services that the patient typically does not select.

IMPORTANT: You're never required to give up your protections from Balance Billing. You also aren't required to get care Out-of-Network. You can choose a Provider or Facility in the Plan's Network.

EXAMPLE: *If a participant has a covered surgery at a Network Hospital, but the doctor who administers the anesthesia to the participant is Out-of-Network, this rule will protect the participant from receiving surprise medical bills from the Out-of-Network Anesthesiologist. The Participant will be responsible only for his/her in-network cost-sharing (i.e., $0 copay for surgery) and cannot be Balance Billed.*

37. **Sleep Apnea Services.** Effective June 1, 2020 the Plan provides for medically necessary obstructive sleep apnea screening and risk assessments, including certain treatment options only with the Aloha Dental Group Provider. Please contact the Plan Office for more information on covered services and limitations.

38. **Autism, Learning Disability & Related Problems.** Subject to the applicable co-payment or coinsurance, diagnosis and treatment of medically necessary Autism Spectrum Disorder, including evaluation or treatment of learning disabilities, minimal brain dysfunction, developmental, learning and communication disorders and Intensive therapies such as Applied Behavior Analysis ("ABA") will be covered. Autism Spectrum Disorders are any of the pervasive developmental disorders as defined in the most recent edition of the Diagnostic and Statistic Manual of Mental Disorders published by the American Psychiatric Association (such as Autism, Asperger Syndrome, and Pervasive Development Disorder). Benefits are payable on the same basis as for the diagnosis and treatment of other comparable physical and/or mental health conditions. No annual or lifetime dollar visits or dollar limits apply to the diagnosis and treatment of Autism Spectrum Disorder.

Diagnosis may include following: Medically necessary assessments, evaluations, neuropsychological evaluations, genetic testing or other tests to diagnose whether the individual has one of the Autism Spectrum Disorders.

Treatment including the following care when prescribed, provided or ordered by a board certified or licensed health care professional who determines the care to be medical necessary:

(i) habilitative or rehabilitative,
(ii) residential treatment,
(iii) inpatient treatment (including partial hospitalization/day treatment),
(iv) pharmacy benefits,
(v) psychiatric & psychological,
(vi) intensive outpatient treatment, and
(vii) outpatient treatment.

Services include the following:

(i) diagnostic evaluations, assessment and treatment planning,
(ii) treatment and/or procedures,
(iii) medications management and other associated treatments,
(iv) individual, family and group therapy,
(v) provider-based care management services, and
(vi) crisis intervention.

Habilitative or Rehabilitative care means professional counseling and guidance services and treatment programs, including, but not limited to, applied behavior analysis supervised by a board-certified behavior analyst, that are necessary to develop, maintain and restore, to the maximum extent practicable, the functioning of an individual. Applied behavior analysis includes the design, implementation and evaluation of environmental modifications, using behavioral stimuli and consequences, to produce socially significant improvement in human behavior, including the use of direct observation, measurement and functional analysis of the relationship between environment and behavior.

Eligible Dependents will be evaluated by the Plan Provider to determine the appropriate treatment modality for their condition.

K. EXCLUSIONS AND LIMITATIONS.

Benefits are **NOT** provided or **LIMITED** for the following:

1. **Not Medically Necessary.** Services or supplies that are not Medically Necessary as defined in Article VI., Section H.

2. **Outside Dates of Coverage.** Services received before the Member's Effective Date or during an inpatient stay that began before the Member's Effective Date. Services received after the Member's coverage ends except as specifically stated under Extension of Benefits.

3. **Excess of UCR.** Any amounts in excess of the Usual, Customary and Reasonable allowance for professional services of non- Prudent Buyer Network providers.

4. **Services Not Listed.** Services not specifically listed as covered services.

5. **No Legal Obligation to Pay.** Services for which the Member is not legally obligated to pay and Services for which no charge is made to the Member. Services for which no charge is made to the Member in the absence of insurance coverage, except services received at a non-governmental charitable research Hospital. Such a hospital must meet the following guidelines:

   A. It must be internationally known as being devoted mainly to medical research;

   B. At least ten percent of its yearly annual expenditure must be spent on research not directly related to patient care;

   C. At least one-third of its gross income must come from donations or grants other than gifts or payments for patient care;

   D. It must accept patients who are unable to pay; and

   E. Two-thirds of its patients must have conditions directly related to the Hospital's research.

6. **Work-Related.** Work-related conditions if benefits are recovered or can be recovered, either by adjudication, settlement or otherwise, under any workers' compensation, employer's liability law or occupational disease law, even if the Member does not claim those benefits.

7. **Active War.** Conditions caused by an act of war.

8. **Governmental Services.** Any service provided by a local, state or federal government agency, including a Veteran's Administration Hospital.

9. **Entitled to Medicare**. Any services to the extent that the Member is entitled to receive Medicare benefits for those services, whether or not Medicare benefits are actually paid. Any services for which payment may be obtained from any other local, state or federal government agency (except Medi-Cal).

10. **Related or Live Together with Provider**. Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.

11. **Custodial Care and Related Changes.** Inpatient room and board charges in connection with a hospital stay primarily for environmental change, physical therapy or treatment of chronic pain. Custodial care or rest cures. Services provided by a rest home, a home for the aged, a nursing home or any similar facility. Services provided by a Skilled Nursing Facility, except as specifically stated in Skilled Nursing Facility under Covered Expenses.

12. **Could Have Been Performed on Outpatient Basis**. Inpatient room and board charges in connection with a hospital stay primarily for diagnostic tests which could have been performed safely on an outpatient basis.

13. **Learning Disabilities and Related Problems**. Treatment for hyperkinetic syndromes, learning disabilities, behavioral problems, mental retardation or autistic disease of childhood.

14. **Dental.** Dental plates, bridges, crowns, caps or other dental prostheses, dental services, extraction of teeth, or treatment to the teeth or gums, except as specifically stated under Covered Expenses. Cosmetic dental surgery or other services for beautification.

15. **Routine Hearing Testing**. Routine hearing tests, except as provided in the Hearing Benefit in the next section.

16. **Optometric.** Optometric services, eye exercises including orthotics, routine eye exams and routine eye refractions. Eyeglasses or contact lenses, except as specifically stated under Covered Expenses.

17. **Certain Occupational Therapy**. Outpatient occupational therapy, except following surgery, injury, or non-congenital organic disease.

18. **Certain Speech Therapy.** Outpatient speech therapy, except following surgery, injury or non-congenital organic disease.

19. **Cosmetic**. Charges in connection with Cosmetic Surgery are covered only if

    A. Within 12 months after and as the result of an injury sustained while insured under this plan;

    B. For replacement of diseased tissue surgically removed while insured under the plan;

    C. For the initial reconstruction of a breast after a mastectomy for which benefits are paid under this plan; and

    D. Repair of bodily damage covered by disease and/or radiation treatment while insured under this plan.

20. **Obesity**. Services primarily for weight reduction or treatment of obesity. This exclusion will not apply to surgical treatment of obesity if:

    A. Surgical treatment of obesity is necessary to treat another life-threatening condition involving obesity; and

    B. It has been documented that non-surgical treatments of obesity have failed.

21. **Transgender Procedures.** Effective January 1, 2017 procedures or treatments to change characteristics of the body to those of the opposite sex unless determined to be medically necessary by a licensed physician.

22. **Sterilization Reversal/Infertility/Artificial Insemination**. Sterilization reversal, treatment of infertility, artificial insemination and in vitro fertilization, including implantation of fertilized egg embryo or gamete transfer procedures and related care.

23. **Orthopedic Shoes**. Orthopedic shoes (except when joined to braces).

24. **Eye Surgery.** Any eye surgery solely for the purpose of correcting refractive defects of the eye such as near sightedness (myopia) and astigmatism.

26. **Acupuncture**. Acupuncture treatment is limited as listed in the schedule of benefits.

27. **After 12 Months.** There is a 12-month filing limit on the submission or claims. Charges for otherwise covered claims submitted more than twelve (12) months after the services or supplies were rendered that are the basis of the claim.

28. **Outside US (For More Than 60 Days).** Services rendered outside the United States to an eligible individual during an absence from the United States for a period of more than sixty (60) days.

29. Commission of a Crime. Charges which result from an injury which arose in the commission of a crime or participation in a riot or insurrection. Whether or not injuries arose on the commission of a crime will be determined by the Board of Trustees in its sole discretion, and may include circumstances in which no criminal charges have been brought.

30. **Miscellaneous Procedures.** Any charges associated with the following procedures or services:

- Radial Keratome
- Lasik Surgery
- Elective Abortions
- Biofeedback and Hypnotherapy
- Myofunctional therapy (facial exercises)
- Behavioral training used for hyperactive children, weight counseling, and similar programs aimed at change behavior
- Holistic medicine, therapeutic injections, chelation treatments

31. **Experimental or Investigative.** Charges for services, treatment, or procedures that are considered Experimental or Investigative in nature. A treatment, procedure, facility, equipment, drug, device or supply will be considered to be Experimental or Investigative if it falls within anyone of the following categories:

1. It is not yet generally accepted among experts as accepted medical practice for the patient's medical and mental health condition.

2. It cannot be lawfully marketed or furnished without the approval of the U.S. Food and Drug Administration or other federal agency, and such approval had not been granted at the time the treatment, procedure, facility, equipment, drug, device or supply was rendered, provided or utilized.

3. It is the subject of ongoing Phase I or Phase II clinical trials, or is the research, Experimental, study or investigational arm of ongoing Phase III clinical trials, or is otherwise 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 diagnoses, or if the prevailing opinion among experts regarding any such treatment, procedure, facility, equipment, drug, device, or supply is that further studies or clinical trials 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 diagnoses.

Determination of whether a treatment, procedure, facility, equipment, drug, device or supply is Experimental or Investigative shall be determined solely by the Trustees, in their sole discretion and judgment, in consultation with experts of their choosing.

For Kaiser enrollees, please refer to the Kaiser evidence of coverage booklet for a definition of what is considered "experimental or investigational."

Note: There is no exclusion for pre-existing conditions under this plan.

VII. KAISER HMO PLAN

The second option available is through Kaiser Permanente a Health Maintenance Organization. If you reside in a Northern California Kaiser Service Area, you have the option to enroll yourself and your eligible Dependents in the Kaiser Permanente Health Plan option "Kaiser". Kaiser does not provide benefits for Participants residing outside of the Northern California Kaiser Service area. Kaiser members must receive all covered care from Providers at Northern California Kaiser Plan Facilities, except in emergency situations. Kaiser's medical care program provides access to services such as routine care with your own personal Plan Physician, hospital care, laboratory, pharmacy services, and many other benefits described in the Kaiser Disclosure Form and Plan booklet. At most Northern California Kaiser Plan Facilities, you can usually receive all of the covered services you may need, including specialty care, pharmacy, and lab work.

Office visits and many of the services you receive at Kaiser are subject to a co-payment, which is due at the time of service.

A separate Kaiser booklet is available at the Plan Office which describes this coverage. If you are interested in Kaiser Health Plan coverage and wish to receive a Kaiser packet, please contact our office at 408-288-4433 or 1/877/827-4239. If you currently have the Kaiser Plan and wish to enroll in the PPO Medical Plan, please complete the enclosed Open Enrollment Election form.

A. PRINCIPAL BENEFITS FOR KAISER PERMANENTE TRADITIONAL PLAN.

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

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

The Board of Trustees believes this coverage is a "grandfathered health plan" under the Patient Protection and affordable Care Act. If you have questions about grandfathered health plans, please call Kaiser's Member service Call Center.

B. ANNUAL OUT-OF-POCKET MAXIMUM FOR CERTAIN SERVICES.

For services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Co-payments and Co-insurance you pay for those Services add up to one of the following amounts:

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

1. **Deductible**	**NONE**	
2. **Lifetime Maximum**	**NONE**	
3. **Professional Services (Plan Provider office visits)**	**You Pay**	**Retiree**
Most primary and specialty care consultations, exams & treatment	$15 per visit	$10 per visit
Routine physical maintenance exams, including well-woman exams	No Charge	
Well-child preventive exams (through age 23 months)	No Charge	
Family planning counseling	No Charge	
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No Charge	
Eye exams	$10 per visit	
Hearing exams	$10 per visit	
Urgent care consultations, exams and treatment	$15 per visit	$10 per visit
Physical, occupational, and speech therapy	$15 per visit	$10 per visit
4. **Outpatient Services**	**You Pay**	**Retiree**
Outpatient surgery and certain other outpatient procedures	$15 per visit	$10 per visit
Allergy injections (including allergy serum)	$3 per visit	
Most immunizations (including the vaccine)	No Charge	
Most X-rays and laboratory test	No Charge	
Health education:		
Covered individual health education counseling	No Charge	
Covered health education programs	No Charge	
5. **Hospitalization Services**	**You Pay**	
Room and board, surgery, anesthesia, X-rays, laboratory tests & drugs	$100 per visit	$35 per visit
6. **Emergency Health Coverage**	**You Pay**	
Emergency Department visits	$50 per trip	

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

7. **Ambulance Service**	**You Pay**	
Ambulance Services	$50 per trip	
8. **Prescription Drug Coverage**	**You Pay**	
Most covered outpatient items in accord with our drug formulary guidelines at Plan Pharmacies or through our mail-order service	Co-payment up to a 100-day supply	
9. **Mental Health Services**	**You Pay**	
Inpatient psychiatric hospitalization	$100 per admission	
Individual outpatient mental health evaluation and treatment	$15 per visit	$10 per visit
Group outpatient mental health treatment	$7 per visit	$5 per visit
10. **Chemical Dependency Services**	**You Pay**	
Inpatient detoxification	$100 per admission	
Individual outpatient chemical dependency evaluation	$15 per visit	$10 per visit

Group outpatient chemical dependency treatment	$5 per visit

11. **Home Health Services**	**You Pay**
Home health care (up to 100 visits per calendar year)	No charge

12. **Other**	**You Pay**
Eyewear purchased at Plan Medical Offices or plan optical sales Offices every 24 months	Amount in excess of $175 allowance
Skilled nursing facility care (up to 100 days per benefit period)	No charge
Covered external prosthetic devices, orthotic devices, and Urological supplies	No charge
Hospice care	No charge

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

For details on your benefit coverage, please refer to Kaiser Permanente's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Kaiser Plan and its participants.

C. COVID-19 COVERAGE DURING PUBLIC HEALTH EMERGENCY PERIOD.

1. COVID-19 Testing, Diagnostic Services or Items Coverage. Effective March 5, 2020, the Plan's HMO coverage through Kaiser will waive all cost-sharing (deductibles, copayments, and coinsurance) for all medically necessary screening and tests to detect COVID-19 during the COVID-19 public health emergency period. Kaiser will also cover serological tests a.k.a antibody tests for COVID-19 used to detect antibodies against the SARS-CoV-2 virus and are intended for use in the diagnosis of the disease or condition of having current or past infection with SARS-COV-2, the virus which causes COVID-19 pursuant to federal and state mandates including Kaiser's own infectious disease medical experts. This COVID-19 coverage extends to any diagnostic services or items including the visit (such as an in-person or telehealth visit), associated lab testing, and radiology services provided in an urgent care center, hospital, an emergency room or medical office that results in an order for an administration of the COVID-19 testing or screening but only to the extent such items and services relate to the furnishing or administration of the test or to the evaluation of the need for a test. This cost-sharing reduction applies to all Kaiser Permanente and other participating providers. Prior authorization is not required for diagnostic services related to COVID-19 testing.

Coverage of Over-the-Counter ("OTC") COVID-19 Tests. Effective for purchases on or after January 15, 2022 and during the public health emergency period, Kaiser will provide coverage for, including reimbursement of, all OTC tests (also known as at-home tests or self-tests): (a) approved, cleared or authorized by the FDA, (b) test that received FDA authorization for emergency use, (c) state authorized test and state has notified the Dept. of HHS, and (d) other tests that the Secretary of HHS determined appropriate in guidance during the public health emergency period, to detect the SARS-COV-2 (the virus that causes coronavirus disease 2019) or the diagnosis of COVID-19, purchased through pharmacies, retail stores and online retailers, without any cost-sharing, prior authorization or medical management requirements and without a prescription or involvement of a health care provider.

Pursuant to federal guidance, the Insurer is permitted to make the following limitations (if applicable) under the Safe Harbors provided under FAQ Part 51:

(a) Cost Limits (Through Pharmacy Network or Direct Coverage). The Insurer is permitted to limit reimbursement from a non-preferred pharmacy or other retailers to the lesser of: (i) the actual price of the test or (ii) $12 per test, provided that the:
(1) Insurer provides access to direct coverage, without cost-sharing (meaning the participant does not pay an upfront cost and instead the plan or its contracted entity pays the preferred pharmacy or retailer directly) of OTC COVID-19 tests through a preferred pharmacy network or other retailers, including direct-to-consumer shipping programs; and
(2) Plan takes reasonable steps to provide adequate access to OTC COVID-19 tests through an adequate number of retail locations (both in-person and on-line locations).
(b) Quantity Test limit. The Insurer is permitted to limit OTC COVID-19 tests without a prescription or provider involvement, to no less than 8 tests per covered individual (ex. Participant, Dependent Spouse, Dependent Child) per 30-day period or calendar month. In applying the quantity limit of 8, the Insurer may count each test separately, even if multiple tests are sold in one package. The Insurer is permitted to set more generous limits although not mandated.

If the above Safe Harbor (a) is not met (for example, if there are delays that are significantly longer than the amount of time it takes to receive other items under the Insurer's direct-to-consumer shipping program), the Insurer must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set limits relating to reimbursement on the amount of OTC COVID-19 tests.

If the above Safe Harbor (b) is not met (for example, OTC COVID-19 test with doctor's note), the Insurer must provide coverage of the OTC COVID-19 test without cost-sharing and cannot deny coverage and cannot set quantity limits.

To address suspected fraud or abuse the Plan is permitted to require reasonable documentation of proof of purchase with a claim for reimbursement for the cost of the OTC COVID-19 test or require a self-attestation.

Please contact Kaiser for more information on how to file a claim for reimbursement or any direct coverage arrangements (if applicable).

2. <u>COVID-19 Treatment</u>. Effective April 1, 2020 and extended through December 31, 2020 unless superseded by government action or extended by Kaiser, if a Kaiser Plan Participant or Dependent is diagnosed with COVID-19, charges such as out-of-pocket costs for treatment of COVID-19 will be covered for inpatient medical, inpatient pharmacy, outpatient medical, office visits, telemedicine, hospitalization, emergency room, urgent care and transportation costs). This means any out-of-pocket costs, co-payments or other cost-share related to a positive COVID-19 diagnosis and treatment (including hospital stay) will be waived by Kaiser.

VIII. HEARING BENEFIT (A SELF-FUNDED PLAN)

A. <u>HEARING BENEFIT RULES.</u>

The Plan will pay for a medically necessary Hearing Benefit, regardless of which medical plan option (ex. Self-funded Anthem Blue Cross PPO or Kaiser HMO Plan option) an eligible "Covered Person "is enrolled in, for the covered hearing benefit charges a Covered Person incurs while otherwise eligible under the Plan. **A "Covered Person" is an Active employee only (but not apprentices) and retirees. Dependents are not eligible for this benefit.**

1. **Percentage Payable**: 80% of Usual, Customary and Reasonable charges, known as UCR. The percentage is applied to the covered hearing benefit charges.

2. **Hearing Benefit Maximum (Non-Apprentice Actives & Retirees Only):** Hearing Aid benefit is limited to $2,000 each 12-month period for each device per ear (for a combined total maximum of $4,000 for both ears) for active employees and retirees. Hearing aid benefits are not available to apprentices and dependents.

3. Although this benefit is not subject to an annual deductible, you will be responsible for the 20% not covered under this benefit and all charges in excess of the Hearing Benefit Maximum of $500.

4. **Covered Hearing Charge**: A "covered hearing charge" is a charge that meets all of the tests listed below:

   a. It is made by a physician or a certified or licensed audiologist for a service or supply that is listed in the Covered Charges List and is furnished to a covered person.
   b. It is incurred by a person while covered for the Hearing Benefit. A charge is incurred at the time the service is rendered or the supply is furnished for which the charge is made.

5. **Covered Charge Limits**: The "covered charge limits" that apply to each service or supply are (a) the usual charge for the service or supply; and (b) the customary charge for the service or supply.

6. **Covered Charges List:**

   a. The charge for an otologic examination made by a physician, but not for more than one examination during any five-year period.
   b. The charge for an audio logic examination made by a certified or licensed audiologist, and the charge for one follow-up visit.
   c. The charges incurred in connection with the purchase of a hearing aid device (monaural or binaural) prescribed as a result of examinations, but only if the examining physician or audiologist certifies that he covered person has hearing loss that may be lessened by the use of a hearing aid device. The charges include the charges for:

   (i) The actual hearing aid device;
   (ii) Ear mold(s);
   (iii)The initial batteries, cords, and other necessary ancillary equipment;
   (iv)A warranty; and
   (v) A follow-up visit within 30 days after the delivery of the hearing aid device.

B. EXCLUSIONS.

No Hearing Benefit will be paid for the following:

1. A hearing aid device that exceeds the specifications of the prescription;
2. Batteries or other ancillary equipment, except those purchased with the Service or supply that is not necessary or that does not meet professionally recognized standards;
3. Service or supply that is otherwise covered by the medical plan the participant is enrolled in; and
4. Apprentices or Dependents.

IX. DENTAL BENEFITS (Delta Dental)

The Plan provides dental care benefits through an insured arrangement with Delta Dental. The Group Number is 2776-001 (Actives), 002 (apprentices) and 003) retirees. A separate booklet, which has been provided for you, is available at the Plan Office which describes this coverage. The Delta phone number is: 800-765-6003.

A. Summary Chart of Dental Benefits.

Below is a summary of your dental benefits. For complete details on your dental benefit coverage, please refer to Delta Dental's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Dental Plan and its Participants.

	Delta Dental PPO Dentists (Plan pays)	Non-Delta Dental PPO Dentists (Plan pays)
Diagnostic & Preventive Services (exams, cleanings, x-rays)	100%	100%
Basic Services (filings, simple tooth extractions, sealants)	90%	75%
Oral Surgery (covered under basic services)	90%	75%
Major Services (crowns, inlays, on lays, and cast restorations)	(Actives & Retirees) 90% (Apprentices) 50%	(Actives & Retirees) 75% (Apprentices) 50%
Prosthodontics (bridges, dentures, and implants)	(Actives & Retirees) 90% (Apprentices) 50%	(Actives & Retirees) 75% (Apprentices) 50%
Endodontics (root canals)	90%	75%
Periodontics (gum treatments)	90%	75%
Orthodontic Benefits (Adults & Dependent children)	90%	75%
Deductibles	$50 per person/$100 per family each calendar year **Note:** The current deductible applies to all benefits except preventive and diagnostic treatment.	
Dental Maximums	Actives & Retirees: $3,000 per person/calendar year Apprentices: $1,500 per person/calendar year	
Orthodontic Maximums	$2,500 Lifetime Maximum	
Dependent Children	Covered until end of the month dependent turns age 26	
Waiting Periods	None for basic benefits, major benefits, prosthodontics & orthodontics.	

X. VISION CARE BENEFITS

The Plan provides vision care benefits through Vision Service Plan www.vsp.com. For PPO Members only The Group Number is 12059939-004. The phone number is 800-877-7195. A separate booklet is available at the Plan Office with complete benefit coverage, limitations, and exclusions. **Kaiser Members must use Kaiser for their vision benefits.**

Vision Services Plan (VSP)
One Market Plaza, Suite 2625, Stuart Street Tower
San Francisco, CA 94105

Member Services: http://www.vsp.com
(800) 877-7195
(800) 428-4833 (toll-free TTY for the hearing/speech impaired)

The Vision Service Plan (VSP) covers each eligible Participant and Dependent for a regular examination and lenses and frames when necessary for proper visual function or correction.

A. To obtain services: To obtain services of a Panel Doctor, an eligible Participant and/or Dependent is requested to contact a VSP participating doctor to make an appointment. Make sure you identify yourself as a VSP member; give your Social Security Number and the group name. The doctor's office will verify eligibility and benefits. If you need to locate a VSP participating doctor, call VSP at (800) 877-7195, or find one at www.vsp.com.

VSP will pay the doctor directly. Except as otherwise provided in this section, you are responsible only for the applicable co-payment **and any additional costs for items only partially covered or not covered. No co-payment applies for contacts**.

If you use a doctor from the VSP network, this assures direct payment to the doctor and guarantees quality and cost control; however, if you decide to use the services of a doctor who is not a VSP Panel Member, you should pay the doctor his or her fee. You will later be reimbursed in accordance with the VSP reimbursement schedule by VSP.

B. Services and Materials:

1. One Vision Examination per 12-month period. The Plan provides for a comprehensive examination of your visual functions once every 12 months, including the prescription of corrective eyewear where indicated.

2. Lenses and Frames. If the vision examination indicates that new lenses or frames or both are necessary for the proper visual health of a covered person, the Plan provides:

(a) Lenses - Actives: **available once each 12 months** if a prescription change is warranted, Single vision, lined bifocal and lined trifocal lenses are covered.
Retirees: **available once each 12 months** if a prescription change is warranted, Single vision, lined bifocal and lined trifocal lenses are covered.

(b) Frames - Actives: **available once each 12 months** if replacement is necessary; frames of your choice are covered up to $120.00 plus 20% off any out-of-pocket expenses.
Retirees: **available once each 24 months** if replacement is necessary; frames of your choice are covered up to $120.00 plus 20% off any out-of-pocket cost if replacement is necessary.

3. Safety Glasses.

Effective January 1, 2022, one pair/per year of safety prescription lenses and frames are covered under the Plan through VSP subject to a $25 copayment only for Active Participants and Apprentices enrolled under the self-funded Anthem Blue Cross medical option. Dependents are not eligible for this benefit. In addition, prescription safety lenses and frames are fully covered when an eligible participant chooses a pair from the VSP ProTec Eyewear collection. The examination to get Prescription Safety glasses is covered under the regular VSP $25 examination. There is no separate copayment for obtaining the examination to get prescription safety glasses

C. Contact Lenses Care: When you choose contacts instead of glasses, your $120.00 allowance applies to the cost of your contacts and the contact lens exam (fitting and evaluation). This exam is in addition to your VISION exam to ensure proper fit of contacts. Current soft contact lens wearers may qualify for a special contact lens program that includes a contact lens evaluation and initial supply of replacement lenses. Learn more from your doctor or vsp.com.

D. Extra Discounts and Savings:

1. Prescription Glasses. Up to 20% savings on lens extras such as scratch resistant and anti-reflective coating and progressives. There is also a 20% discount off additional prescription glasses and sunglasses.

2. Contacts. 15% off cost of contact lens exam (fitting and evaluation) available from the same VSP doctor who provided your eye exam within the last 12 months.

E. Your Co-Pays (subject to change):

Exam and Prescription Glasses	$ 25
Contacts	No co-pay applies

F. Out-of-Network (Non-VSP): If you choose to receive vision care services and materials from a doctor who is not a panel member of VSP or from a dispensing optician, you will be reimbursed in accordance with the following schedule:

1. **Professional Fees**

Vision Examination	$ 50

2. **Materials**

Single Vision Lens, up to	$ 50
Lined Bifocal Lenses, up to	$ 75
Lined Trifocal Lenses, up to	$100
Frames, up to	$ 70

3. **Contact Lenses** up to $105

These amounts may change at any time. Please call VSP for vision care request forms at (800) 877-7195 prior to visiting your provider or at **www.vsp.com**.

G. VSP Grievance Procedures: If a Participant has a complaint/grievance (hereafter 'grievance') regarding VSP service or claim payment, the Participant may communicate the grievance to VSP by using the form which is available by calling VSP Customer Service Department's toll-free number (800) 877-7195 Monday through Friday 6:00 a.m. to 6:00 p.m. Pacific Standard Time. Grievances may be filed in writing within 180 days with VSP at 3333 Quality Drive, Rancho Cordova, CA 95670.

If you are dissatisfied with the results after exhausting VSP's grievance procedures, you may file a written appeal with the Plan's Board of Trustees, as provided in the Claims and Appeals Procedures described in section B, page 82.

The California Department of Managed Health Care ("Department") is responsible for regulating health care service plans and receiving complaints regarding VSP (and similar programs). If you need the Department's help with a complaint involving an emergency grievance or with a grievance that has not been satisfactorily resolved by VSP, you may call the Department's help center toll-free at 888-466-2219. The hearing and speech impaired may use the California Relay Service's toll-free telephone number 1-877-688-9891 (TDD) to contact the Department.

Plan complaint forms and instructions are available online at the Department's website, http://www.dmhc.ca.gov/dmhc_consumer/pc/pc_complaint.aspx.

NOTE: VSP's grievance process and the Department's complaint review process is in addition to any other dispute resolution procedures that may be available to you, and your failure to use these processes does not preclude your use of any other remedy provided by law. ***For details on your benefit coverage, please refer to Vision Service Plan's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Vision Plan and its participants.***

XI. LIFE INSURANCE BENEFIT (MetLife Insurance Company)

The Life Insurance benefit for Active Participants was increased from a $10,000 benefit to a $100,000 benefit on account of the death of an active IBEW Local 617 member who dies on or after January 1, 2015. The benefit increase applies to the basic Life Insurance Benefit and the Accidental Death and Dismemberment benefit. As with the prior policy, there are certain exclusions to the benefit. Those did not change. Effective September 1, 2022, the life insurance benefits will be provided through MetLife Insurance Company (previously Anthem Blue Cross). A separate Evidence of Coverage booklet is available at the Plan office which describes this coverage.

Website for MetLife: Because coverage is through self-bill, there isn't a MetLife member website. You will have access to view only information at https://portal.metlink.com

Addresses:

Billing: MetLife
PO Box 803323
Kansas City, MO 64180-3323

Life Claims: MetLife
PO Box 6100
Scranton, PA 18505-6100

Phone number for participants: 1-800-638-6420

Group Policy Number: 5374409

For additional details on your benefit coverage, please refer to MetLife's' s Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Life Insurance Plan and its participants.

XII. PRESCRIPTION DRUGS

A. SAV-Rx IS PHARMACY BENEFIT MANAGEMENT COMPANY.

The Board of Trustees has contracted with Sav-Rx, a nationally recognized Pharmacy Benefit Management Company, to administer the Trust's prescription drug program. The current prescription drug plan design, including co-payments and general program provisions, did not change with Sav-Rx. Sav-Rx is one of the larger fully integrated independent pharmacy benefit management (PBM) providers in the United States. Their retail network and mail service pharmacies are integrated through their on-line real-time system, providing you a complete pharmacy history when needed. The Plan's prescription drug benefits are available to eligible Participants and their Dependents including out-of-state Retirees covered under the Hartford coverage (effective January 1, 2022).

Sav-Rx is endorsed by the International Brotherhood of Electrical Workers (the IBEW International) as the PBM of choice in their Pharmacy Coalition. By participating in the National IBEW Pharmacy Coalition, the San Mateo Electrical Workers Health Care Plan benefits from greater prescription discounts resulting in lower program cost to the Plan.

Sav-Rx is Pharmacy Benefit Manager if you have questions regarding prescription drug coverage or network pharmacies, we encourage you to call Sav-Rx Customer Service directly at 866-233-IBEW (4239). If you have general questions or experience any difficulties, contact United Administrative Services (UAS) at (408) 288-4433 or (877) 827-4239. There are two primary components to your prescription drug program:

1) Retail Network Pharmacy for short-term medications, and
2) Sav-Rx Mail Service Pharmacy for long-term medications.

Through the retail pharmacy you can obtain up to a 34-day supply. Through the mail order pharmacy, you can obtain up to a 90-day supply. For specialty medications, you can get up to a d0-day supply at either a retail or mail order pharmacy.

Retail Service. For short-term medications, such as antibiotics, it is important that you use a participating Sav-Rx Pharmacy in order to get the best price and the greatest savings. Sav-Rx has a network of more than 64,000 pharmacies providing prescription services at convenient locations across the country. To locate a network pharmacy near you, call Sav-Rx or you may visit wwew.savrx.com**.**

Mail Service. For long-term medications, the Sav-Rx Mail Service Pharmacy is a cost effective and convenient choice for your long-term needs (usually saving you money). Regular orders are processed within

24 hours of receipt and mailed First-Class for convenient home delivery. When you need a refill simply call Sav-Rx for help with your order. Your co-payment is required at the time of your order, which will require your Sav-Rx identification number (with each prescription). Additional mail order forms are available at www.savrx.com. Sav-Rx will contact your physician or pharmacy to obtain your prescription for you.

This is how much you will pay (at this stage) for your prescriptions.

	GENERIC	**FORMULARY**	**NON-FORMULARY**
RETAIL	**$5.00**	**$15.00**	**$25.00**
MAIL	**$10.00**	**$30.00**	**$50.00**
SPECIALTY	**$25.00**	**$25.00**	**$25.00**
	GENERIC	**FORMULARY**	**NON-FORMULARY**
RETAIL	**$10.00**	**$15.00**	**$30.00**
MAIL	**$20.00**	**$30.00**	**$60.00**
SPECIALTY	**$30.00**	**$30.00**	**$30.00**
	GENERIC	**FORMULARY**	**NON-FORMULARY**
RETAIL	**$10.00**	**$25.00**	**$40.00**
MAIL	**$20.00**	**$50.00**	**$80.00**
SPECIALTY	**$40.00**	**$40.00**	**$40.00**

Note: Through the retail pharmacy you can get up to a 34-day supply. Through the mail order pharmacy, you can get up to 90-day supply. For specialty medications you can get up to a 30-day supply at either a retail or mail order pharmacy.

B. COVERED DRUGS.

Most maintenance medications are covered by your Plan. These include but are not limited to: insulin, diabetic supplies, blood pressure, cholesterol and more. Certain classes are excluded from coverage such as experimental, fertility and weight loss.

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

(1) Federal Legend Drugs
(2) State Restricted Drugs
(3) Compounded Medications
(4) Insulin on Prescription Only
(5) Needles and Syringes
(6) OTC Diabetic Supplies

You will receive generic substitutes whenever possible, unless your physician will not allow a generic substitute or you specify otherwise.

Effective January 1, 2019, outpatient prescription medications (ex. smoking cessation drugs and/or over the counter items) that are prescribed by a licensed provider and consistent with the U.S. Preventive Services Task Force A & B recommendations and guidelines set by the federal government pursuant to the Affordable Care Act, as amended will be covered as a preventive benefit subject to medical management techniques to determine frequency, method, treatment, setting or medical necessity for non-formulary medications. Please contact the

Trust Fund Office for a current list of covered preventive drugs and any cost-sharing requirements. Please note any brand products that have a generic equivalent, you will be responsible for the difference in cost.

Below is a list of Sav Rx covered preventive medications:

Covered items are paid by the Plan at 100% for generic products and the applicable copayment for brand products. Brand products that have a generic equivalent will charge the patient the difference in cost unless otherwise noted.

DRUG / DRUG CLASS	
Women's Health	
Oral contraceptive (i.e. combination, progestin only, extended cycle, Plan B, Ella)	Covered
Rx - Non-oral contraceptive (i.e. patch, ring, injection, implant, IUD, Cervical Cap, diaphragm):	Covered
OTC – Non-oral contraceptive (i.e., female condom, sponge, spermicide etc.):	Covered
Over the counter contraceptive (i.e., male condom):	Excluded
Abortifacient (i.e., Misoprostol)	Excluded
Preventative Services Covered with prescription	
Generic Aspirin for men and women age 45-79.	Covered
Generic Aspirin for women of childbearing age at risk for preeclampsia**	Covered**
Oral Fluoride as prescribed through age 5.	Covered
Generic OTC Folic Acid Supplements for women to age 55.	Covered
Iron Supplement Drops as prescribed through age 1	Covered
Vitamin D age 65 and over	Covered
Erythromycin Opthoint as prescribed through age 1	Covered
Immunizations:	Covered
Routine Childhood and Adult Immunizations	Covered
Herpes Zoster (Shingles) – male & female age 60 and over	Covered
Influenza	Covered
Tobacco Cessation:	
Rx and OTC - up to 90 days - up to twice annually	Covered
Breast Cancer Chemo preventative (i.e., tamoxifen, raloxifene) *	Covered
Colorectal Cancer Screening Tests (i.e., colonoscopy prep – PEG Solution, Golytely)*	Covered

*100% cost share will be placed through a secondary message instructing the pharmacy to call for 100% coverage in the case of preventative use.
**Claim will reject for prior authorization to determine if the woman is at risk for preeclampsia. If so, authorization will be given for coverage at 100%.

Preventative Statins (Default):	
Clinically Managed Statins (select generics)	Covered at 100%
Brand statins***	Covered at applicable copay
Other Generic Statins***	Covered at applicable copay

***100% cost share will be placed through a secondary message instructing the pharmacy to call for 100% coverage in the case of preventative use.

C. EXCLUSIONS.

The following are excluded from coverage unless specifically listed as a benefit under "Covered Drugs".

(1) Contraceptive medications or devices (including without limitation oral, patches, rings) unless prescribed by a licensed physician and considered a preventive service medication for women approved by the Food and Drug Administration (FDA), pursuant to the Affordable Care Act.
(2) Anorexiants
(3) Retin-A
(4) Growth Hormones
(5) Fertility Medications also known as Fertility Agents
(6) Smoking Deterrents unless prescribed by a licensed physician and is considered a preventive service medication under the recommended government guidelines pursuant to the Affordable Care Act.
(7) Non-Federal Legend Drugs
(8) Therapeutic devices or appliances
(9) Drugs whose sole purpose is to promote or stimulate hair growth
(10) Drugs labeled "Caution-limited by Federal Law to investigational use," or experimental drugs, even though a charge is made to the individual.
(11) Medication for which the cost if recoverable under any Workers' Compensation or Occupational Disease Law or any State or Governmental Agency, or medication furnished by any other Drug or Medical Service for which no charge is made to the member.
(12) Medication which is to be taken by or administered to an individual, in whole or in part, while he or she is a patient in a licensed hospital, rest home, sanitarium, extended care facility, skilled nursing facility, convalescent hospital, nursing home or similar institution which operates on its premises or allows to be operated on its premises, a facility for dispensing pharmaceuticals.
(13) Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.
(14) Drugs or devices prescribed solely for the treatment of sexual dysfunction.
(15) Anti-Obesity
(16) Vitamins (including prenatal)
(17) Anti-anxiety agents
(18) Anti-acne agents.

There is a $100 per year deductible for retirees for retail prescription drug expenses.

D. GENERIC VS. BRAND.

Generic drugs have been approved by the Food and Drug Administration ("FDA") as safe and effective. Generic drugs contain the same active ingredients in the same amounts as the brand name product. The generic version works like the brand name drug in dosage, strength, performance and use. Generics may differ in color, shape, size or flavor from the brand product; however, the differences do not affect the performance, safety or effectiveness of the generic drug. Generic drugs are often substantially cheaper than the brand name version, but have not been compromised in quality and effectiveness. The FDA requires that generic drugs be as safe and effective as brand-name drugs.

1. If they are the same in quality and effectiveness, why are Generic drugs cheaper than Brand drugs?

Generic drugs are only cheaper because manufacturers have not had the expenses of developing and marketing a new drug. When a new drug enters the market, a patent is granted that gives the company that initially developed the drug an exclusive right to sell the drug for a particular length of time. Once the patent expires, then generics can enter the market after FDA approval.

2. There is No Difference.

a. A generic drug has been FDA approved and has the same quality and effectiveness as a brand drug, but usually costs less.
b. A Preferred brand name drug, or formulary drug has been FDA and clinically approved by Sav-Rx but does not have a generic alternative.
c. A Non-Preferred brand name drug, or non-formulary drug has been FDA and clinically approved by Sav-Rx Care, but has a lower cost alternative that has also been clinically and FDA approved.

E. RETAIL PHARMACY.

You may present your Sav-$Rx card at any of over 64,000 retail network pharmacies nationwide to purchase your prescription medication. Your pharmacist may call Sav-Rx with any questions (1-866-233-4239). To verify local pharmacy participation in the plan net- work, you can search on-line at www.savrx.com or call member services at 1-866-233-4239. **For medications you take routinely, it is recommended that you utilize the Mail Order Service for convenience and lower cost.**

F. REFILLS (INCLUDING INTERNET ORDERS).

Refills may be called in 24 hours a day, 7 days a week to 1-866-233-4239. You also may request a refill online at www.savrx.com

G. REFILL REQUESTS BY MAIL.

As noted above, to reduce your costs, you are recommended to order your prescription medication from the Sav-Rx Mail Order Pharmacy. The mail order should be used for your long-term maintenance medications. Using the Sav-Rx mail order may offer cost savings to you (and to the Plan). Regular orders are processed within 24 hours of receipt and mailed First-Class for convenient home delivery.

Your doctor may E-scribe new prescriptions to Sav-Rx or call in a new prescription to Sav-Rx at 1-866-233-IBEW (4239). You may also mail your prescription to Sav-Rx, PO Box 8, Fremont, NE 68026. **Note that your copayment is required with every order**, and be sure to reference your Sav-Rx identification number with each prescription. Additional mail order forms are available at www.savrx.com.

H. COMMON QUESTIONS.

You may Sav-Rx to find out more about your prescription copays, netw3ork locations and clinical programs. A Sav-Rx agent will be ready to provide you with assistance 24/7. Phone: 1-866-233-4239.

1. What do I do if I lost my prescription benefits card?
Phone Sav-Rx at 1-866-23-4239 to request a new card by mail.

2. How do I use my prescription benefits card for a family member?
Your prescription benefits card is active for you and any other eligible, enrolled family members for as long as your benefits/ eligibility is active. To obtain prescription benefits for an enrolled family member, the fulfilling pharmacy just needs the member's name and your benefits information. The Sav-Rx Care pharmacy system takes care of the rest.

3. I received a call from a Sav-Rx Care staff member. Why would they call me?
You may be contacted by Sav-Rx Care if there is concern about drug interactions or other safety issues related to medications you are taking. In addition, our staff also looks for ways to help you save out-of-pocket costs. If we believe that a lower cost, but equally safe and effective medication may be an option for you, we will let you and/or your doctor know. This is a free service offered to all members.

4. **Who can I call to ask questions about the medications a family member is taking?**

Your physician is the best source of information regarding medications taken, since they have your full medical history to reference and have direct responsibility for your care. Your pharmacist can also answer general questions concerning dosing, side effects, or how best to take a particular medicine.

a. Medication furnished by any other drug or medical service for which no charge is made to the member.
b. Any prescription refilled in excess of the number of refills specified by the physician, or any refill dispensed after one year from the physician's original order.

XIII. ACCIDENTAL DEATH AND DISMEMBERMENT BENEFIT

The Plan provides Accidental Death and Dismemberment benefits through MetLife to Active Participants only. A separate Evidence of Coverage booklet is available at the Plan office which describes this coverage. ***For details on your benefit coverage, please refer to MetLife's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the AD&D Plan and its participants.***

Effective September 1, 2022, the AD&D insurance benefits will be provided through MetLife Insurance Company.

Website for Metlife: Because coverage is through self-bill, there isn't a MetLife member website. You will have access to view only information at https://portal.metlink.com

Addresses:

Billing: MetLife
PO Box 803323
Kansas City, MO 64180-3323

AD&D Claims: MetLife
PO Box 6100
Scranton, PA 18505-6100

Phone number for participants: 1-800-638-6420

Group Policy Number: 5374409

When, within ninety (90) days after and as a direct result of an accidental injury, you sustain one of the losses listed below, a dismemberment benefit or the accidental death benefit is paid to you or your beneficiary. This Plan is incurred by MetLife.

$100,000 will be paid if you are an active Participant under age 70 for loss of:

- Life
- Both Hands or Both Feet
- Sight of Both Eyes
- One Hand and One Foot

- One Hand and Sight of One Eye

$50,000 will paid if you are an active Participant age 70 or older.
One-half the benefits shown above are paid for loss of:

- One Foot and Sight of One Eye
- One Hand and One Foot
- Sight of One Eye

Only one benefit is payable as a result of all losses sustained in any one accident, that is the one for which the greatest benefit is payable.

Loss means, with respect to hands and feet, the actual severance at or above the wrist or ankle joints; with respect to eyes, the entire and irrecoverable loss of sight. Limitations: the benefit does not cover loss caused by: war or any act of war (whether or not declared); disease or infection (except infection of an accidental wound); suicide, intentional self-inflicted injury, or attempt at suicide while sane or insane.

For details on your benefit coverage, please refer to Met Life's Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Plan and its Participants.

For details on your benefit coverage, please refer to your Evidence of Coverage Booklet. The Evidence of Coverage Booklet is the binding document between the Hearing Plan and its participants.

XIV. EMPLOYEE ASSISTANCE PROGRAM

A. <u>ELIGIBILITY & TREATMENT</u>. The Plan's Employee Assistance Program ("EAP") are available if you are covered under the self-funded PPO plan or the Kaiser Permanente HMO plan but see limitations below. The EAP is a voluntary free service which provides confidential assistance to participants and their eligible dependents who are experiencing difficulty dealing with personal and work-related problems that affect their lives. All contacts with the EAP are kept strictly confidential in accordance with federal and state laws. The EAP program is considered an excepted benefit and is a separate program from the mental health and substance abuse benefits offered through the Plan. You are not required to use or exhaust your EAP benefits before you are eligible for the Plan's major medical plan.

1. **Optum EAP Program (Primary Administrator for EAP services).** The Plan has contracted with Optum to administer the Plan's Employee Assistance program (EAP). Through the Optum EAP program you and your dependents can get confidential help for a wide range of concerns, including work or family conflicts, stress, depression, and grief counseling. The program provides confidential assistance and support, short-term counseling, unlimited telephonic support, and 5 in-person sessions (including virtual visits), per issue for free each year plus access to a wealth of information through the Optum digital platform and mobile application. The Optum EAP is available to all eligible Kaiser HMO and Self-funded PPO members under the Plan.

   You can call Optum's toll-free number 24 hours a day, seven days a week. When you call, you will immediately be connected to a Behavioral Health Professional with a clinical master's degree and at least four years of clinical experience to help you find the right resource for your particular situation. If you have limited English proficiency, Optum will provide language assistance services to ensure

you are able to communicate effectively with the Optum personnel in your preferred spoken language. These language assistance services are provided at no cost to you.

Optum
toll free: (800)622-7276
www.liveandworkwell.com
(Enter the access code IBEW617)

B. <u>COVERED SERVICES AVAILABLE.</u>

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Optum EAP. The Optum counseling services available through the EAP include:

- Access to a 24-hour toll-free hotline and intervention service.
- Assessment services.
- Short-term counseling sessions, in-person and over the telephone. In-person sessions (including virtual sessions) are limited to 5 sessions per person per issue each calendar year at no charge to you.
- Referral to community resources for legal, tax, eldercare, and childcare problems.
- Access to online tools and resources.
- Individual, couple and family assessments for most types of personal problems including:

- Single Parenting - Unresolved Grief
- Eating Disorders - Marital Problems
- Dual Careers - Sexual Problems
- Anxiety - Retirement Concerns
- Depression - Career Change
- Parent-child Conflict - Financial/Legal Concerns
- Job "Burnout" - Physical Abuse
- Work Related Problems - Alcohol or Drug Problems
- Life Transition - Problems of Adolescence
- Aging Parents - Stress
- Death & Dying - Compulsive Gambling

C. NON-COVERED SERVICES.

No EAP benefits are provided for:

- Services not provided through Optum such as:
  - (i) Physician services, including services from a psychiatrist
  - (ii) Hospital services (inpatient and outpatient services)
  - (iii) Diagnostic laboratory and diagnostic and therapeutic radiological services
  - (iv) Home Health services
  - (v) Emergency health care services
  - (vi) Drugs and medications
- Face-to-face counseling sessions after you meet the limit of 5 sessions per person each calendar year. (Additional counseling services are covered under the medical benefits and may require cost-sharing.)
- Services provided after your eligibility for coverage ends.
- Substance Use treatment services: please contact Beat It! at 800-828-3939 for all substance use concerns

D. OPTUM EAP CHOICE OF PROVIDERS.

Each Participant who requests that Covered Services be provided will be assigned by Optum to a Participating Provider who will coordinate the Covered Services to be received by the Participant from that Participating Provider. If you desire to change your assignment to a particular Participating Provider, you should inform Optum. Optum will consider all such requests, but will have sole discretion to determine whether you will be assigned to another Participating Provider or permitted to obtain Covered Services from a provider other than a provider that has been arranged by Optum.

If your Participating Provider is terminated by Optum from the Participating Provider network, you may request that Optum arrange for the continuation of Covered Services for up to ninety (90) days from the Participating Provider's date of termination. Continuation of Covered Services will allow appropriate time for you to transition to another Participating Provider. Continuation of Covered Services is subject to the five (5)

Counseling session maximum per problem each contract year in accordance with the EAP Benefit Plan Summary and only applies if you have an acute condition, serious chronic condition or are pregnant.

E.
OPTUM EAP GRIEVANCE PROCEDURES.

Pursuant to Optum EAP grievance procedures, every Participant has the right to communicate a complaint to Optum either by telephone at 800-999-9585, or in writing to the:

Grievance & Appeals Department
U.S Behavioral Health Plan, California
425 Market Street, P.O. Box 2839
San Francisco, CA 94126

Or by facsimile at 1-800-984-7584;

Or at the USBHPC Web site: www.liveandworkwell.com

A complaint must be communicated in the method stated above within 180 calendar days of the initial non-authorization or the event giving rise to the complaint.

An exception to the one hundred and eighty (180) calendar day filing requirement can be made by the Complaint Coordinator on the basis of either a telephone call or written request by the complainant which reasonably explains their inability to meet the filing deadline (e.g., Participant seeking a second opinion or a medical condition precluded Participant from making complaint).

Optum will provide the Participant with written acknowledgment within five (5) calendar days of such receipt of the complaint, including the date received, the name, telephone number and address of a representative of USBHPC who may be contacted regarding the status of the complaint. Optum will investigate the complaint and resolve it. All complaints by Participants concerning the adequacy or competency of clinical services will be immediately referred to the Optum Medical Director. A Participant will receive written notification of the resolution of his or her complaint within thirty (30) calendar days of Optum's receipt of the complaint. Optum will supply the Participant with its Grievance Procedure and complaint forms upon request.

The limited English proficient ("LEP") Participant has the right to free language assistance services. If requested by the LEP Participant, Optum provides assistance in the filing of any complaint including assisting the LEP Participant with access to an interpreter.

Complaint acknowledgment and resolution letters are sent in English with a notice informing Participants of the availability of free language assistance services. These services include oral interpretation and, for grievance documents, translation services in the most frequently spoken languages.

Expedited Review of Grievances.

For Participant grievances involving an imminent and serious threat to the health of the Participant, including but not limited to, severe pain, potential loss of life, limb, or major bodily function, Optum shall immediately inform the Participant, in writing, of the Participant's right to notify the Department and provide the Participant

and the Department with a written statement on the disposition or pending status of the grievance no later than three (3) calendar days from receipt of the grievance.

Request for Voluntary Mediation and DMHC Review of Grievances.

In addition to you or an agent acting on your behalf, may request voluntary mediation with Optum prior to exercising your right to submit a grievance to the Department of Managed Health Care. The use of mediation services shall not preclude your right to submit a grievance to the Department upon completion of mediation. In order to initiate mediation, you, or the agent acting on your behalf, and Optum shall voluntarily agree to mediation. Expenses for mediation shall be borne equally by both sides. The Department shall have no administrative or enforcement responsibilities in connection with the voluntary mediation.

XV. DISABILITY BENEFIT

A. ELIGIBILITY.

In order to be eligible for disability benefits under this section an IBEW 617 member must be:
(a) an eligible participant in the Plan;
(b) have at least twelve (12) out of 15 months of coverage in this Plan;
(c) eligible for medical benefits at the time the disability is incurred;
(d) cannot be registered on the IBEW Local 617 out-of-work list or any other IBEW Local out-of-work list; and
(e) cannot have worked for a non-signatory electrical contractor.

Exception: If you have worked for a non-signatory electrical contractor, no disability benefit is paid in that situation!

Entitled to up to 12 months of Monthly Payments. Effective for disability that commenced on or after January 1, 2020, the disability benefit will be provided for up to 12 months for each disability subject to a 12 month break if re-qualifying for another disability. This means a disability for an unrelated cause will be payable only if separated by twelve (12) months after returning to active employment and the other qualifying requirements under this section are met.

The definition of disability does not change. A person will be considered "disabled" during the 12 months of disability if they are unable, solely because of disease or injury, to work as an electrician as determined by the Board of Trustees. To be considered disabled, a person must be under the care of a licensed physician, have presented sufficient proof of the disability and cannot be registered on the IBEW Local 617 out-of-work list (or any other IBEW Local out-of-work list).

Waiting Period Before Benefit Commences. There is a one month waiting period during which you have the disability before the 12-month benefit commences.

Proof that a person continues to be disabled may be required at reasonable intervals by the Trust. If a person fails to furnish proof and/or refuses to be examined by a physician if so requested (designated and paid for by the Trust), you will no longer be considered disabled. Disability benefits under the Plan will be suspended for lack of cooperation.

There is no change to the Plan's current exclusions as certain disabilities are excluded from coverage. A person will not receive benefits for disability arising from any of the following causes:

- The commission of, or participation in a crime (and no actual conviction is required);
- An act of war, (whether declared or not), insurrection, rebellion or participation in a riot or civil commotion;
- Where such bodily injury or disease is due to such person's willful engagement in any illegal activity or occupation or the self-inflection of such, or any other injury resulting from chronic alcoholism, use of alcohol, or the use of narcotics, unless the same were administered pursuant to the orders of a licensed physician.

The benefit provided if you qualify for the Disability under this Plan is coverage under the Plan (with no self-payment required) for up to the one-year period, as well as a $1,000 monthly payment for up to 12 months for each disability to you as a result of your disability (and such payment is taxable). The Plan issues a Form-1099 showing receipt of the payments during the year.

** The term "electrical construction industry" shall include any public or private employment in a unit represented by I.B.E.W. Local 617 for which contributions are paid or required to be paid to this Trustee for the Disability Plan.

B. AMOUNT OF DISABILITY BENEFIT – $1,000 Monthly Benefit.

The Disability Benefit consists of a maximum monthly amount of $1,000. Benefits will commence on the last day of the month in which the completion of the elimination period below occurs. Benefit payments shall be pro-rated on a daily basis for the month benefits commence and for the month benefits cease. This amount may be changed in the future.

C. ELIMINATION PERIOD – 30 Day Period Prior to Benefits Paid.

A person must be continuously and totally disabled for a period of thirty (30) days before being eligible for paid benefits. Total disability will be deemed to have commenced as of the first visit with a licensed physician or hospital for such disability.

D. DURATION OF BENEFIT PAYMENTS.

For disabilities, which occur up to age 63, benefits shall cease for the months following attainment of age 65, upon recovery, death, or as provided as the following paragraph below, whichever shall occur first:

a) After 12 months of benefit payment, or
b) Upon recovery, or
c) Upon death.

Disability payments will be made to persons meeting the qualifications for a period commencing with the last day of the month in which the completion of the elimination period occurs, after commencement of a certified disability and ending upon the date of recovery or as otherwise provided.

Benefits will stop with the month that any beneficiary accepts a benefit payment from any electrical industry Retirement Plan (e.g., NEBF, IBEW or the San Mateo County Electrical Industry Retirement Trust).
Benefits will stop with the first month that a beneficiary starts receiving regular Social Security Benefits (but does not apply to Social Security Disability Benefits). In no event shall benefit payments, in the aggregate, exceed 12 months for any one related disability.

The Board of Trustees has the total and absolute discretion in determining whether sufficient documentation has been presented and may designate a medical provider to evaluate a Participant (at any time).

E. DEFINITION OF DISABILITY.

A person will be considered "disabled" during the 12 months of disability if unable, solely because of disease or injury, to work as an electrician as determined by the Board of Trustees.

To be considered disabled, a person must be under the care of a licensed physician and cannot be registered on the IBEW Local 617 out-of-work list. Proof that a person continues to be disabled may be required at reasonable intervals by the Trust. If a person fails to furnish proof or refuses to be examined by a physician (designated and paid for by the Trust), such person will no longer be considered disabled. Disability benefits under the Plan will be suspended for lack of cooperation.

F. BENEFITS IMPROPERLY PAID.

Any benefit paid to a person not entitled thereto shall be repaid to the Trust. Notwithstanding any other provisions of this Plan, if such improper payments are not repaid to the plan, overpayments shall be deducted from future benefits payable to the recipient.

G. PERIODS OF DISABILITY.

Periods of disability are defined as follows:

a) Participant shall receive a maximum of up to a 12-month period for benefits for each related period of disability.
b) A disability for an unrelated cause shall be payable only if separated by 12 months after returning to active service and the qualifying requirements stated under the eligibility section.
c) Only one elimination period will be required with respect to successive periods of disability, which are considered as one period of disability.
d) Under the Plan, pregnancy shall be considered as a related disability.

H. LIFE, AD&D, MEDICAL AND DENTAL BENEFIT CONTINUATION.

This Plan shall pay the total cost of the Plan's Life, AD&D, Medical and Dental coverages. For a person receiving disability benefits from the Plan for more than 50% of the month, but not to exceed 12 months for any one eligible disability.

I. EXCLUSIONS.

Certain disabilities are beyond the scope of this Disability Benefit Plan. Therefore, a person will not receive benefits for disability arising from any of the following causes:

- Intentional self-inflected injuries, alcoholism or drug abuse;
- The commission of, or participation in a crime (and no actual conviction is required);
- An act of war, (whether declared or not), insurrection, rebellion or participation in a riot or civil commotion;
- Where such bodily injury or disease is due to such person's willful engagement in any illegal activity or occupation or the self-inflection of such, or any other injury resulting from chronic alcoholism, use of alcohol, or the use of narcotics, unless the same were administered pursuant to the orders of a licensed physician.

J. THIRD PARTY RESPONSIBILITY.

If an eligible person's disability is caused by an act or omission of a third party, the disabled participant is required to assign his or her claim for reimbursement, indemnification, damages or other redress to the Plan up to the amount of disability benefits paid or payable to the disabled person. As a condition for receipt of benefits under the Plan, any such disabled participant agrees to reimburse the Plan for any recovery from a third party and/or agrees to permit the Plan to intervene or otherwise participate in any lawsuit, arbitration or other proceeding.

XVI. COBRA CONTINUATION COVERAGE

A. ELIGIBILITY FOR COBRA.

A federal law known as the Consolidated Omnibus Budget Reconciliation Act of 1985 ("COBRA"), requires that group health plans offer covered Employees and their Dependents the opportunity to elect to pay a temporary extension of health coverage (called "Cobra Continuation Coverage" or "COBRA") in certain instances (called "qualifying events") where coverage under the Plan would otherwise end. To receive this continuation coverage the Employee, spouse and/or Dependent(s) must make timely monthly payments (including the stub payment form) directly to the Plan (or, the Bank Depository if so, designated by the Plan Office).

When you no longer have sufficient hours in your Reserve Hour Bank, your COBRA coverage will run concurrently with any continuation of coverage described in section B on page 24. **In other words, your COBRA extension period is reduced by the number of months under the Active Subsidized Self-Pay coverage.**

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

A qualifying event is any of the following:

1. The death of the Participant;
2. The Participant's termination of employment (except for gross misconduct);
3. A reduction in the Participant's hours;
4. The divorce or legal separation of the Participant and his or her spouse; or
5. A child no longer meets the definition of a Dependent.
6. The Participant becomes entitled to Medicare.

To receive this COBRA coverage, a Participant end/or his eligible Dependents must file a timely application following the qualifying event and make monthly self-payments in an amount determined by the Board of Trustees directly to the Bank Depository (designated by the Plan Office), including the payment stub.

B. COBRA RULES.

1. COBRA Continuation Coverage: Upon payment of the required monthly premium (which is usually set at 102% of the applicable cost of medical coverage), you and/or your dependent(s) may elect COBRA continuation coverage as follows.

a. Termination of Employment or Reduction in Hours. A Participant or dependent may elect COBRA for medical benefits and prescription drug coverage only (core), or medical, prescription drug, dental and vision coverage (core and non-core benefits) for a period of up to 18 months if you lose your health coverage because of termination of your Covered Employment or a reduction in hours (including having used all hours in your Reserve Hour Bank), unless such termination is due to your Gross Misconduct. This 18-month period is reduced by the number of months of Active Subsidized Self-Pay.

By electing COBRA continuation coverage, you will be electing to maintain benefits on behalf of your eligible Dependents. If you do not elect COBRA continuation coverage, your spouse may independently elect such coverage on behalf of himself or herself and eligible Dependents if applicable and pay the required premium.

b. Disability-Extended Coverage for 29 Months. For an additional premium and subject to certain notice provision, an Employee or other eligible Dependent may elect continuation coverage for an additional 11 months if the Employee or eligible Dependent is determined by the Social Security Administration to be totally disabled and permanently disabled as of the date of the Employee's termination or employment or reduction in hours (i.e., the qualifying event which invoked COBRA coverage) or within sixty days of the COBRA coverage. You pay 150% of the applicable premium for the additional 11 months of coverage. To qualify for this special extended COBRA eligibility. You must report the Social Security disability determination to the Plan Office before the initial 18 months of COBRA coverage expires and within 60 days after receipt of the Social Security determination). +This disability extension ends immediately if the disabled individual recovers.

2. Thirty-Six Month COBRA Coverage for Dependents: A Dependent spouse or child who would otherwise lose health coverage is eligible for continuation coverage for up to 36 months because of the following qualifying events:

(1) The death of the Employee;
(2) Divorce or legal separation of the Employee and spouse; or
(3) A child ceases to meet the Plan's definition of Dependent.

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

> EXAMPLE: A Participant's Spouse is on COBRA continuation coverage due to the Employee's termination of employment. The Participant passes away after 12 months of coverage during the 18-month period. Their death is a second "qualifying event" and entitles the spouse to the remaining balance of 24 months (36 month maximum minus the 12 months that has already been covered).

The period of coverage under this section is reduced by any period in which the Employee or dependent was provided coverage by the Plan at lower cost than coverage under this section pursuant to the subsidized self-pay provisions of the Plan.

C. ELECTION OF COBRA COVERAGE.

Within 60 days after the Plan Office is informed in writing of an event entitling you and/or your Spouse or Dependent child(ren) to COBRA coverage, the Plan Office will provide you with information concerning the

coverage available and its cost. You and/or your dependent(s) must elect COBRA coverage within 60 days after your coverage under the Plan ends or the date you receive the election form, whichever is later. Anyone electing COBRA coverage must pay for it retroactive to the date he or she lost coverage under the Plan. Payment for this retroactive coverage is due within 45 days after the date COBRA coverage is first elected. After this first premium, there is a 30-day grace period for making future COBRA payments. No benefit claim will be honored unless the required payment has been received for the period in which the claim was incurred.

If you elect COBRA, you will be entitled to the same health coverage that is provided to active employees or family members in the Plan. Therefore, if there are any changes to the Plan for active employees, your benefits will also change.

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

1. CORE COVERAGE- Provides coverage for medical and prescription drugs only.
2. CORE AND NON-CORE COVERAGE – Provides coverage for medical, prescription drugs, dental, orthodontia, vision and hearing aid.

The premium for COBRA will increase each year. You have the option of changing Medical Plans at the time you elect COBRA subject to residing in the HMO's service area. COBRA premiums are based on your Plan election.

D. YOUR OBLIGATION TO NOTIFY THE PLAN OFFICE.

You are required to notify the Plan Office if you become divorced or legally separated or if there are any other changes in life circumstances that may affect your eligibility for benefits or those of a Dependent.

Plan Participants are also required to immediately notify the Plan Office if your spouse or other enrolled Dependent no longer resides with you. Once a Dependent (including a spouse) no longer resides in your home, that Dependent would no longer meet the definition of an eligible dependent. Consequently, that Dependent would not qualify for coverage under the Plan. A spouse who does not reside with you, is no longer entitled to coverage under the Plan. Please be aware that a spouse no longer residing in the Participant's home, without a legal separation or divorce, is not a qualifying event under COBRA. However, provided the Plan Office is notified within 30 days of the date of a separation (legal or by joint decision) or a spouse who no longer resides in your home will be allowed the opportunity to purchase coverage at an unsubsidized rate, determined by the Board of Trustees, for up to six months after the date of separation. If within the 6-month period you are able to obtain a legal separation or a final divorce decree, coverage may be extended for a total period not to exceed 36 months (including the first six months of purchased coverage).

E. TERMINATION OF COBRA COVERAGE.

COBRA continuation coverage will end before the 18-, 29- or 36-month continuation coverage period expires if:

1. **Failure to Timely Pay Premium**: You and/or your Dependent(s) fail to pay the required contribution on time;

2. **Coverage Under Other Plan**: You or your dependent(s) become covered by another group health plan after your COBRA election (except a plan that excludes or limits benefits for a pre-existing condition affecting you or your Dependent and such exclusion or limitation is enforceable under the Health Insurance Portability and Accountability act (HIPAA);

3. **Medicare Entitlement**: You and/or your Dependent(s) become entitled to Medicare after having elected COBRA;

4. **No Longer Disabled**: You or your Dependent(s) qualified for 29-month maximum continuation period based on disability, but are no longer disabled;

5. **Employer No Longer Contributes**: Your Employer who contributed on your behalf ceases to be contributing employer; or

6. **No Active Plan**: The Plan and your employer cease to maintain any health plan for active employees or retirees.

F. CALIFORNIA CONTINUATION BENEFITS REPLACEMENT ACT (Cal-COBRA).

Under the California Continuation Benefits Replacement Act ("Cal-COBRA"), Small Employers with 2 to 19 employees are required to offer terminated Employees and their Dependents the opportunity to continue health insurance coverage. Cal-COBRA is the California program that is similar to Federal COBRA. If applicable, once you have exhausted Federal COBRA Continuation Coverage which generally lasts for up to 18 months, Cal-COBRA may extend continuation coverage for an additional 18 months, up to a combined total of 36 months. However, Employers with over 20 or more employees are subject to Federal COBRA. **Please contact Kaiser for Cal-COBRA eligibility questions.**

XVII. SURVIVING SPOUSE CONTINUATION COVERAGE

A. SURVIVING SPOUSE OF DECEASED ACTIVE PARTICIPANT.

Upon the death of a covered active participant, a surviving spouse and Dependent child(ren), if any, shall continue to be eligible for benefits until the participant's reserve hours are exhausted for fully subsidized continued coverage under the Plan. After the reserve hours are exhausted, the Surviving Spouse may elect to continue coverage for another 6 months at no cost and an additional 18 months at a 50% subsidized rate. In addition, in order to be eligible for surviving spouse continued coverage, the surviving spouse and any eligible dependent child(ren) must have been covered by the Plan at the time of the active participant's death.

For widows' continuation coverage rules of deceased retirees, please refer to Article III, Section E.

B. TERMINATION OF CONTINUATION COVERAGE.

Surviving spouse continuation coverage shall terminate upon the occurrence of the following events:

1. Surviving spouse will cease to be eligible for coverage under the Plan effective the date of re-marriage of a surviving spouse; or
2. Dependent child(ren) is no longer an eligible dependent under the Plan rules; or
3. Surviving spouse or Dependent child(ren) becomes eligible for coverage under any other group health plan.

XVIII. FEDERAL NOTICES

A. NEWBORNS' AND MOTHERS' HEALTH PROTECTION ACT OF 1996.

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

In accordance with Federal Law, plans and insurers may not require that a provider obtain preauthorization from the plan or insurer for prescribing either of the foregoing lengths of stay. However, Federal Law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother and/or her newborn earlier than 48 hours or 96 hours as applicable. Also, you may be required to obtain precertification for any days of confinement that exceed 48 hours (or 96 hours). Furthermore, plans and insurers may not set levels of benefit or out-of-pocket costs so that any portion of the 48-hour (or 96 hour as applicable) stay is treated in a manner that is less favorable to the mother or newborn than any earlier portion of the stay.

B. WOMEN'S HEALTH AND CANCER RIGHTS ACT OF 1998.

Your Plan covers medical and surgical benefits for mastectomies. This coverage will be provided in a manner determined in consultation with the attending physician and the patient, for:

1. All states of reconstruction of the breast on which the mastectomy was performed (including coverage for nipple and areola reconstruction, nipple and areola repigmentation to restore the physical appearance of the breast, as a required stage of reconstruction);

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

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

The coverage is subject to the Plan's annual deductibles and coinsurance provisions. For more information, please call either Kaiser at 800-464-4000, if you are enrolled under the Kaiser HMO plan) or the Plan Office at 408-288-4400, if you are enrolled under the self-funded PPO plan.

C. PRIVACY OF PROTECTED HEALTH INFORMATION UNDER HIPAA.

This Plan will use and disclose protected health information ("PHI") in accordance with the uses and disclosures permitted by the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). This Section of the booklet describes how PHI about you may be used and disclosed and how you can get access to PHI. Please review this section carefully.

PHI is defined as individually identifiable health information that is maintained or transmitted by this Plan in any form or medium (oral, written, or electronic). Individually identifiable health information is health information, including demographic information, that is created or received by a health care provider, employer, health care clearinghouse or this Plan and relates to the past, present or future physical or mental health condition of you and/or your eligible dependents, including payment information for the provision of health care. When held by this Plan, it also means information that either identifies you and/or your eligible dependents directly or indirectly, in that one has a reasonable belief that you or your eligible dependents can

be identified using the information. For example, your name, address, birth date, marital status, Social Security Number, and choice of health plan would be considered PHI. Other examples are the amount of contributions paid by your employer for your coverage, or whether you are an active employee, retiree, or Medicare enrollee.

The Plan is required by law to:

1. **Maintain the privacy of Your PHI and not use or share your PHI other than as permitted under HIPAA and unless you tell the Plan it can in writing;**
2. **Provide You with certain rights with respect to Your PHI;**
3. **Give You notice of the Plan's legal duties and privacy policies regarding Your PHI;**
4. **Follow the terms of this section of the Benefit Booklet until modified;**
5. **Notify you promptly if a breach occurs that may have compromised the privacy or security of your PHI.**

Potential Impact of State Laws. The HIPAA Privacy Rule generally does not take precedence over state privacy or other applicable laws that provide individuals greater privacy protections. As a result, to the extent state law applies, the privacy laws of a particular state, or other federal laws, rather than the HIPAA Privacy Rule, might impose a privacy standard under which the Plan will be required to operate. For example, the Plan will follow more stringent state privacy laws that relate to use and disclosure of PHI concerning HIV or AIDS, mental health, Substance Abuse, genetic testing, reproduction rights, and so on.

For more information please see:
www.hhs.gov/ocr/privacy/hipaa/understanding/consumers/noticepp.html.

THE FOLLOWING USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION (PHI) AND CORRESPONDING RIGHTS AND DUTIES APPLY TO YOU AND YOUR ELIGIBLE DEPENDENTS:

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

2. Required Uses and Disclosures of PHI: This Plan must disclose PHI to you upon request to access your own PHI, with limited exceptions, or to request an accounting of PHI disclosures. Use and disclosure of PHI may be required by the Secretary of U.S. Department of Health and Human Services ("HHS") and its Office of Civil Rights ("OCR") or other authorized government organizations to investigate or determine this Plan's compliance with the Privacy Rule or when required by a court order. Use and disclosure of PHI may also be required when the Plan believes in good faith that such disclosure is necessary to reduce or prevent a serious threat to your health and safety or the health and safety of another individual or the public.

3. Agreed to Uses and Disclosures of PHI by You After an Opportunity to Agree or Disagree to the Disclosure: This Plan will disclose PHI to family members, other relatives or close personal friends if the information is directly relevant to the family or friend's involvement with your health care or payment for such care and you have either agreed to the disclosure or been given an opportunity to object and have not objected. However, PHI of persons who are deceased for more than fifty (50) years is not protected under the HIPAA privacy and security rules.

4. Allowed Uses and Disclosures of PHI For Which Authorization or Opportunity to Object is Not Required: This Plan will use or disclose PHI without your authorization or opportunity to object when required by law, or to law enforcement officials, public health agencies, research facilities, coroners, funeral directors and organ procurement organizations, judicial and administrative agencies, military and national security agencies, worker's compensation programs and correctional facilities.

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

This Plan may disclose summary health information to the Board of Trustees or a Business Associate. Summary health information is PHI, which includes claims history and claims experience, and from which identifying information has been deleted in accordance with the Privacy Rule.
These uses and disclosures are more fully described in this Plan's Privacy Policy Statement and Notice of Privacy Practices for Protected Health Information. Additional copies of these documents may be obtained from the Plan Office.

5. Your Individual Rights: HIPAA and the Privacy Rule afford you the following rights:

- **Right to Request Restrictions.** You (or your personal representative) have the right to request restrictions on how this Plan will use and/or disclose PHI for treatment, payment or health care operations, or to restrict uses and disclosures to family members, relatives, friends or other persons identified who are involved in your health care or payment for such care. However, this Plan is not required to agree to such a request. If this Plan agrees, it is bound by the restriction except when otherwise required by law, in emergencies, or when the restricted information is necessary for treatment. You will be required to complete a form requesting any restriction. If you wish to make a request for restrictions, please make your request in writing to the Plan's Privacy Officer at the address noted below.

- **Right to Choose Someone to Act for You (Personal Representative).** You may exercise your rights through a Personal Representative, who will be required to produce evidence of his/her authority to act on your behalf before he/she will be given access to your health information or be allowed to take any action for you. The Plan Office will verify that the person has this authority and can act for you before it takes any action. Proof of such authority may take one of the following forms: (a) notarized power of attorney for health care purposes or (b) court order of appointment of the individual as your conservator or guardian.

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

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

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

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

- **Right to Notice in Event of Breach.** You have the right to receive and the Plan is required to provide a Notice to you, as soon as reasonably possible, but no later than 60 days after discovery of a breach of your unsecured PHI. There will be a presumption that any unauthorized acquisition, access, use, or disclosure of your PHI, in violation of the Privacy rule is a breach, *unless* the Plan demonstrates that there is a low probability that your PHI has been compromised based on the results of a risk assessment or an exception permitted by the Privacy Rule applies. This Plan has implemented a policy to require the performance of a risk assessment in all cases of impermissible uses or disclosures of PHI to ensure your PHI will not be compromised and intends on complying with any future guidance on risk assessments.
- **Right to Restrict Disclosure of Health Information if Paying Out-of-Pocket.** If you fully paid for services out-of-pocket and you request that the Health Care Provider not disclose your PHI related to those services to the Plan, the Health Care Provider must accommodate your request, except where the Health Care Provider is required by law to make a disclosure.

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

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

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

7. This Plan's Duties: In accordance with the Privacy Rule, only certain employees may be given access to your PHI. The Plan Office has designated this group of employees to include Mail Clerks, Eligibility Certifiers, Supervisors and Managers. The employees described above may only have access to and use and disclose PHI for plan administration functions. A mechanism shall be provided for resolving issues of noncompliance, including disciplinary sanctions or termination, to any person who does not comply with the Privacy Rule.

This Plan and if applicable, the Insurer (ex., Kaiser) is required by law to provide you with its **Notice of Privacy Practices** ("Notice") upon request at any time. The privacy practices for coverage through Kaiser (and the other Insured Carriers such as Delta Dental or Vision Service Plan) are subject to its own notice. You can view Kaiser's own Notice at www.kaiserpermanente.org. The Notice must be distributed by this Plan to new employees and dependents upon enrollment. You will be advised at least once every three years of the availability of the Notice and how to obtain a copy of it. This Plan is required to comply with the terms of the Notice as currently written. However, this Plan reserves the right to change its privacy practices and to apply the changes to any PHI received or maintained by this Plan prior to the date of the change. This Plan will promptly revise and distribute the Notice within 60 days if there is a material change in its privacy policies and procedures.

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

8. Authorization to Use or Disclosure Your PHI: Except as provided for in this section or as permitted by law, the Plan will not release your PHI without your written authorization. Even in situations in which release of PHI may be permitted as described above, the Plan may request your written authorization to release information to the Board of Trustees or others. The Plan Administrator's office has an Authorization

Form that you may sign to authorize release of all or part of your PHI. The following uses and disclosures will be made only with your written authorization subject to your right to revoke, amend, or limit your authorization in writing, at any time:

- **Marketing Authorization.** This Plan will not use and/or disclose PHI for purposes of marketing. Marketing is defined as a communication that encourages the purchase or use of a product or service, such as sending a brochure detailing the benefits of a certain medication that encourages it use or purchase. (However, this Plan may use PHI without authorization in certain situations, including but not limited to sending information describing the participating providers in its provider network(s), and the benefits provided under the plan, providing information for the management of treatment, or recommending alternative treatment, providers, or health coverage.)
- **Psychotherapy Notes**. Psychotherapy notes are separately filed notes about your conversations with your mental health professional. Although this Plan does not routinely obtain psychotherapy notes, it must generally obtain your written authorization before the Plan will use or disclose psychotherapy notes about you.
- **Sale of PHI.** The Plan is prohibited from directly or indirectly receives financial or non-financial remuneration in cash or in kind (including granting license rights) from a third party in exchange for your PHI unless permitted under HIPAA or with your prior written authorization. This Plan does not sell nor does it intend on selling your PHI.
- **Fundraising Purposes.** Except as permitted under HIPAA or with your prior written authorization, the Plan cannot use or disclose your PHI for fundraising purposes. You have the right to opt out of receiving any fundraising communications whether received in writing or over the phone. This Plan does not use nor does it intend to use your PHI for fundraising purposes.
- **Genetic Information.** Your PHI includes genetic information. Although this Plan does not routinely obtain genetic information, in regards to underwriting, premium rating, or similar activities, the Plan will not use or disclose genetic information about an individual, as prohibited under the Genetic Information Nondiscrimination Act of 2008.
- **Child Immunization Proof to Schools.** The Plan may disclose proof of immunization of a student to the school prior to admitting the student, where State or other law requires such information, upon obtaining the consent of the parent, guardian or student of consenting age.
- **Other Uses of Health information.** Other uses and disclosures of health information not covered by this Notice or the laws that apply to the Plan will be made only with your written permission. If you provide us permission to use or disclose health information about you, you may revoke that permission, in writing, at any time. If you revoke your permission, we will no longer use or disclose health information about you for the reasons covered by your written authorization. You understand that we are unable to take back any disclosures we have already made with your permission.

9. <u>Duties of the Board of Trustees With Respect to PHI</u>: This Plan may disclose PHI to the Board of Trustees for Plan administration purposes. This may include information pertaining to claims and appeals, including a review of a subrogation claim, or Participant inquiries in limited circumstances, or summary health information so that the Board may solicit premium bids from health insurers or similar entities. The Trustees have amended this Plan's Trust Agreement and signed a certification agreeing not to use or disclose your PHI other than as permitted by the plan documents, the Privacy Rule, or as required by law. The Trustees' uses and disclosures are more fully described in this Plan's Privacy Policy Statement and/or Notice of Privacy Practices For Protected Health Information. Additional copies of these documents can be obtained from the Plan Office.

10. <u>Right to File Complaints</u>: If you believe your privacy rights have been violated, you may file a complaint with the Plan Office or with the Secretary of the U.S. Department of Health and Human Services. If you wish to file a complaint with this Plan or have any questions regarding the uses or disclosures of your PHI (i.e., access, amendment or accounting of PHI), you may contact the Privacy Officer at:

United Administrative Services
P.O. Box 5057
San Jose, CA 95150-5057
Phone (408) 288-4400

A complaint may also be filed with the U.S. Department of Health and Human Services at 200 Independence Avenue S.W., Washington, D.C. 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. This Plan will not retaliate against you for filing a complaint.

11. Security Standards Under HIPAA: The Board of Trustees will implement reasonable and appropriate safeguards to protect the confidentiality, integrity, and availability of electronic protected health information that the Fund creates, receives, maintains, or transmits on behalf of the Plan pursuant to 45 C.F.R. Section 164.504(f)(1)(ii), enrollment or disenrollment information disclosed pursuant to 45 C.F.R. Section 164.504(f)(1)(iii), or information disclosed pursuant to an authorization under 45 C.F.R. Section 164.508. In implementing such safeguards, the Trustees will:

(1) Ensure that the Adequate Separation required by the HIPAA Security Rule is supported by reasonable and appropriate security measures;

(2) The Trustees will ensure that any agent, including a sub-contractor, to whom it provides electronic protected health information, agrees to implement administrative, physical, and technical safeguards that reasonably and appropriately protect the information that it creates, receives, maintains or transmits on the Plan's behalf; and

(3) The Trustees will report to the Plan any security incident of which it becomes aware.

D. MENTAL HEALTH PARITY AND ADDICTION EQUITY ACT OF 2008 (MHPAEA).

The Mental Health Parity and Addiction Equity Act of 2008 ("MHPAEA") is a federal law that prevents large group health plans (such as this Plan) and health insurers (such as Kaiser) that provide mental health or substance abuse benefits from imposing less favorable benefit limitations, including financial requirements (e.g., deductibles, copayments, coinsurance and out of pocket limitations) and treatment limitations (e.g., number of visits or days of coverage) on those benefits than on medical and surgical benefits offered. As such, the limitations applicable to mental health or substance abuse benefits can be no more restrictive than the predominant limitations applied to substantially all medical and surgical benefits. Pursuant to the Final MHPAEA rules, the Plan or Health Insurer will provide any current participants or potential participants, or contracting providers, upon request, the criteria for medical necessity determinations with respect to mental health/substance abuse benefits and the reason for any denial of reimbursement or payment for services with respect to mental health/substance abuse benefits will also be provided upon request.

It is the intention of the Board of Trustees and the contracted insurers (Kaiser Permanente) that the Plan's benefits be provided in compliance with the requirements of MHPAEA and lawful regulations issued thereunder. For more information on MHPAEA, please visit the Department of Labor website at *www.dol.gov/ebsa/mentalhealthparity/*.

E. CONSOLIDATED APPROPRIATIONS ACT OF 2021 ("CAA").

Effective June 1, 2022, the Plan rules have been amended to comply with certain provisions of Division BB of the Consolidated Appropriations Act under the No Surprise Act (Title I) and Transparency (Title II) provisions, including any subsequent implementing regulations as it relates to the CAA.

1. **Identification Cards (CAA Section 107).**

The Plan (via Anthem Blue Cross) or Insurer's (for its Kaiser HMO option) Identification Cards (physical or electronic) issued to a participant or its eligible dependents will include: (a) the amount of the in-network and out-of-network (if any) deductible and out-of-pocket maximums, (b) telephone number and website address to seek further consumer assistance. Please contact the Trust Fund Office or Kaiser for more information depending on which Plan option you are enrolled in.

2. **Ensuring Continuity of Care (CAA Section 113).**

When a provider or contracted facility is removed from the self-funded Plan or Insurer's (as applicable) coverage, following termination of the provider/facility contract between the Plan or Insurer and the Provider/Facility, the Plan (through Anthem Blue Cross) and Insurer (such as Kaiser) will timely notify participants or their eligible dependents who are receiving continuing care for a serious and complex condition (serious and complex condition means an acute illness that is a condition that is serious enough to require specialized medical treatment to avoid reasonable possibility of death or permanent harm or in the case of chronic illness a condition that is life-threatening, degenerative, potentially disabling or congenital and requires specialized medical care over a prolonged period of time) from that provider or facility that:
(a) the Provider/Facility is no longer part of the Plan's network and
(b) the Participant or eligible Dependent has the right to continue receiving transitional care for up to ninety (90) days at the in-network cost sharing and at the same terms that would have applied had termination not occurred.

Kaiser is responsible for sending the appropriate notice to Kaiser enrollees. Please contact Anthem Blue Cross if you are enrolled in the self-funded PPO option for questions about continuity of care.

3. **Accuracy of Provider Directory Information (CAA Section 116).**

   a. **Verification Process.** Not less frequently than once every ninety (90) days the Plan (through Anthem Blue Cross) or Insurer (such as Kaiser for the HMO Plan option) will verify and update its provider directory information included on the self-funded Plan or Insurer's database (as applicable). Providers are required to submit regular updates to the plan to assist with the verification and update process, including notice of material changes to their provider directory information. The database of provider directories must then be updated within two (2) business days of the plan receiving such data from the providers.

   b. **Response Protocol.** The Plan (through Anthem Blue Cross) or Kaiser for the HMO Plan option will respond to a participant or dependent's request (whether by telephone, electronic, web-based or internet-based), within one (1) business day of the request, about a provider's network status. The Plan must also retain communication records for two (2) years.

   c. **Database.** The Plan (through Anthem Blue Cross) or Kaiser for the HMO Plan option (as applicable) will maintain a public website directory that contains a list of each of its contracted and facility providers, relevant information (name, address, specialty, number, digital contact information) and post information on balance billing protections and appropriate federal and state agency contacts to report violations.

   d. **Cost-Sharing for Services provided Based on Reliance on Incorrect Provider Network Information.** If participant or dependent provides documentation (ex. received through database, provider directory or response protocol) that he/she received and relied on incorrect information from the Plan about a provider's network status prior to the visit and the item or services would otherwise be covered under the plan if

furnished by a participating provider/facility, the Plan cannot impose cost-sharing amount greater than in-network rates and it must count towards the participant or dependent's in-network out-of-pocket maximum and in-network deductible. If a provider submits a bill to an enrollee in excess of the in-network cost-sharing amount and the enrollee pays, the provider must refund that excess amount with interest.

4. <u>Surprise Billing Protections (CAA Sections 102 and 105).</u>

A. Balance Billing Prohibition. Participants and dependents are prohibited from being balance billed for ***(1) out-of-network emergency services***, ***(2) non-emergency services performed by an out-of-network provider received at in-network facility, and (3) out-of-network air ambulance services***. Providers are prohibited from holding patients liable for excess amounts not covered by the Plan or Insured coverage.

B. Cost-Sharing Limits. In addition, for the three above-mentioned surprise items and services **(#1, #2 and #3)** any cost-sharing (such as copayment, coinsurance or deductible) must not be greater than the in-network cost sharing amount and must count towards the Plan's in-network deductible and out-of-pocket maximums, as of the items and services were provided by a participating provider. The participant or dependent's cost-sharing is based on the recognized amount. By statute, the recognized amount is (in order of priority) for only out-of-network emergency services and non-emergency services provided by an out-of-network provider at participating facilities:

1. Amount determined by All-Payer Model Agreement, if applicable;
2. Amount under specified state law (as applied to plans regulated by state law);
3. The lesser of the billed charge or Qualifying payment amount (is the median of the contracted rates for similar services in a particular geographic area-based on the metropolitan statistical area adjusted by the consumer price index for inflation for items or services furnished during 2023 or subsequent years).

For *out-of-network air ambulance bills* the cost-sharing limit must be calculated by using the lesser of the: (1) billed charge or (2) qualifying payment amount.

C. Determination of Out of Network Rates. By statute, the total amount to be paid to a provider/facility must be based on (less any cost-sharing from participant or dependent) the following out-of-network rate, in order of priority:

1. Amount determined by All-Payer Model agreement, if applicable,
2. Amount under specified state law (as applied to plans regulated by state law);
3. Amount agreed upon by Plan/Insurer and Provider/Facility; and
4. Amount determined by Independent Dispute Resolution Entity.

D. Patient Protections Disclosure Requirements Against Balance Billing.

Self-funded Plans and Insurers (if applicable) are required to make publicly available, by posting on the website of the Plan or Insurer and including on each Explanation of Benefits for an item or service as it relates to: (1) emergency services or (2) non-emergency services provided by non-participating provider at in-network facility, balance billing and patient protections in certain circumstances and appropriate government agency contact information if the participant or dependent believes the provider/facility has violated the No Surprise Act provisions.

Please contact the Trust Fund Office for more information if you are enrolled in the self-funded PPO option. Please contact Kaiser for more information if you are enrolled in the Kaiser HMO option.

B. Out-of-Network Rate Independent Dispute Resolution Process for Certain No Surprise Act Items and Services (CAA Section 103).

A federal Independent Dispute Resolution ("IDR") process (also known as an arbitration procedure) is required for disputes involving out-of-network rates between the Plan/Insurer and Out-of-Network provider/facility ("disputing parties") as it relates only to:

(1) out-of-network emergency services,
(2) non-emergency services provided by a non-network provider at an in-network facility
(3) out-of-network air ambulance services; and
(4)Furnished to a covered participant or dependent who did not receive notice and/or did not provide adequate consent to waive the balance billing protections with regard to such items and services, pursuant to 45 CFR 149.410(b) or 149.420(c)-(i), as applicable.

The Departments have established the Federal IDR portal to administer the Federal IDR Process, available at https://www.nsa-idr.cms.gov.

Not all items and services are eligible for the federal IDR process. But, before initiating the IDR process, the disputing parties must first initiate a 30-day open negotiation period (meaning must engage in open negotiations within 30 days of receiving initial payment or denial) to settle an out-of-network payment rate for covered items and services under the No Surprise Act. However, the Trust Fund reserves the right at any time in its sole discretion to settle a claim by agreement with a Non-Contract Provider, provided that, if the settled Claim is covered by the No Surprise Act the settlement does not result in higher participant or dependent cost-sharing as permitted under the No Surprise Act.

Summary of Steps Preceding Federal IDR Process	
START	A furnished covered item or service results in a charge for emergency items or services from an OON provider or facility, for non-emergency items or services from an OON provider with respect to a patient visit to certain types of in-network facilities, or for air ambulance services from an OON provider of air ambulance services.
Within 30 calendar days	**Initial Payment or Notice of Denial of Payment** Must be sent by the plan, issuer, or carrier no later than 30 calendar days after a clean claim is received.
30 business days	**Initiation of Open Negotiation Period** An open negotiation period must be initiated within 30 business days beginning on the day the OON provider receives either an initial payment or a notice of denial of

	payment for the item or service from the plan, issuer, or carrier.
	Open Negotiation Period Parties must exhaust a 30-business-day open negotiation period before either party may initiate the Federal IDR Process.

NOTE: If any federal court case including, government guidance, regulations, and/or subsequent law invalidates any portion of the IDR process, as it relates to the No Surprise Act, then the invalidated portions will also not apply to this Plan.

In case of a failed open negotiation period, either party may initiate the federal IDR process as follows:

Timeline	Independent Dispute Resolution (Federal IDR Process)
4 business days	**Federal IDR Initiation** Either party can initiate the Federal IDR Process by submitting a Notice of IDR Initiation to the other party and to the Departments **within 4 business days** after the close of the open negotiation period. The notice must include the initiating party's preferred certified IDR entity. (**Note:** The Federal agencies have issued a standard notice with the required information that the initiating party must include to satisfy the IDR initiation notice requirement)
3-6 business days after initiation	**Selection of Certified IDR Entity** The non-initiating party can accept the initiating party's preferred certified IDR entity or object and propose another certified IDR entity. A lack of response from the non-initiating party **within 3 business days** will be deemed to be acceptance of the initiating party's preferred certified IDR entity. If the parties do not agree on a certified IDR entity, the Departments will randomly select a certified IDR entity on the parties' behalf. If random selection is necessary, the Departments will make the selection no later than **6 business days** after IDR initiation. The certified IDR entity may invoice the parties for administrative fees at the time of selection (administrative fees are due from both parties by the time of offer submission).
3 business days after contingent selection	**Certified IDR Entity Requirements** Once contingently selected, **within 3 business days,** the certified IDR entity must submit an attestation that it does not have a conflict of interest and determine whether the Federal IDR Process is applicable, thereby finalizing the selection.
10 business days after finalization of selection	**Submission of Offers and Payment of Certified IDR Entity Fee** Parties must submit their offers **not later than 10 business days** after finalization of selection of the certified IDR entity. Each party must pay the certified IDR entity fee (which the certified IDR entity will hold in

	a trust or an escrow account), and the administrative fee when submitting its offer (unless the administrative fee has already been paid). If the certified IDR entity fee and administrative fee are not collected from a party, the certified IDR entity will not accept the non-paying party's offer.
30 business days after finalization of selection	**Selection of Offer** A certified IDR entity has **30 business days** from the date of finalization of its selection to determine the payment amount and notify the parties and the Departments of its decision. The certified IDR entity must select one of the offers submitted.
30 calendar/ business days after determination	**Payments Between Parties of Determination Amount & Refund of Certified IDR Entity Fee** Any amount due from one party to the other party must be paid **not later than 30 calendar days** after the determination by the certified IDR entity. The certified IDR entity must refund the prevailing party's certified IDR entity fee **within 30 business days** after the determination.

Administrative Fee. Both parties are responsible for an administrative fee to participate in the Federal IDR process. If the certified IDR entity attests to having no conflicts of interest and concludes that the Federal IDR Process applies, the certified IDR entity must collect the administrative fee from both parties and remit the fee to the Departments. The administrative fee is based on an estimate of the cost to the Departments to carry out the Federal IDR process. The certified IDR entity retains the non-prevailing party's certified IDR entity fee as compensation unless the parties settle on an OON rate before a determination. If the parties settle or withdraw the dispute, the certified IDR entity will return half of each party's fee payment, unless directed otherwise by the parties.

Batched Items and Services. Batching means multiple qualified items or services that are considered jointly as part of one payment determination by a certified IDR entity for purposes of the federal IDR process. In order for a qualified IDR item or service to be included in a batched item or service, the qualified IDR item or service must meet the criteria set forth in 26 CFR 54.9816-8T(c)(3), 29 CFR 2590.716-8(c)(3), and 45 CFR 149.510(c)(3).

Certified IDR Entity. Certified IDR entity means an entity responsible for conducting determinations under 26 CFR 54.9816-8T(c) and 54.9816-8(c), 29 CFR 2590.716-8(c), and 45 CFR 149.510(c) that meets the certification criteria specified in 26 CFR 54.9816-8T(e), 29 CFR 2590.716-8(e), and 45 CFR 149.510(e) and that has been certified by the Departments.

Factors Considered by IDR Entity.
In determining which offer to select, the certified IDR entity must consider:
(1) The QPA(s) for the appliable year for the qualified IDR item or service; and
(2) Additional information relating to the offers submitted by the parties, which does not include information on prohibited factors (explained below).

When making a payment determination, the certified IDR entity must not consider the following factors:

- Usual and Customary charges including payment or reimbursement rates expressed as a proportion of usual and customary charges);

- Amount that would have been billed by the provider, facility, or provider of air ambulance services with respect to the qualified IDR item or service had the balance billing provisions of 45 CFR 149.410, 149.420, and 149.440 (as applicable) not applied; or
- Payment or reimbursement rate for items or services furnished by the provider, facility, or provider of air ambulance services payable by a public payor, including under the Medicare program under title XVIII of the Social Security Act; the Medicaid program under title XIX of the Social Security Act; the Children's Health Insurance Program under title XXI of the Social Security Act; the TRICARE program under chapter 55 of title 10, United States Code; chapter 17 of title 38, United States Code, or demonstration projects under Section 1115 of the Social Security Act. This provision also prohibits consideration of payment or reimbursement rates expressed as a proportion of rates payable by public payors.

NOTE: The above section is subject to change pursuant to federal guidelines and/or future regulatory changes.

C. External Review Rights for Certain No Surprise Act Items and Services (CAA Section 110)- For Self-Funded PPO Plan Option.

This External Review process is intended to comply with the No surprises Act external review requirements. The Plan will comply with an applicable external review process, as described in 26 CFR 54.9815-2719(d), 29 CFR 2590.715-2719(d), and 45 CFR 147.136(d) and any subsequent implementing regulations. As such, eligible participants and dependents have the right to request external review after he/she has exhausted the Plan's current internal claims and appeals rules, upon receipt of an adverse benefit determination as it relates to whether the Plan is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations for certain No Surprise Act claims and services mentioned in this section. This means that, generally, you may only seek external review after a final determination has been made on your appeal. External Review is available only with respect to the following types of claims (whether urgent, concurrent, pre-service or post-service claim is denied):

(1) Out-of-network emergency services,
(2) Non-emergency services provided by a non-network provider at an in-network facility and
(3) Out-of-network air ambulance services.

External review is permitted only in certain cases for adverse benefit determinations (including a final internal adverse benefit determination) by the plan or insurer that involves medical judgment, including but not limited to, those based on the plan's or insurer's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, as well as a consideration of whether the plan or insurer is complying with the surprise billing and cost sharing protections under ERISA sections 716 and 717 and §§ 2590.716-4 through 2590.716-5 and 2590.717-1.

To illustrate, the scope of claims eligible for external review include:

1. *Whether a particular item or service constitutes treatment for emergency services.*
2. *Whether services provided by an out-of-network provider at in in-network facility is subject to the No Surprise Act.*

3. *Whether an individual was in a condition to receive Patient protection notice under the No Surprise Act and able to waive the right to those protections.*
4. *Whether a provider has coded the claim correctly, consistent with the treatment the patient actually received.*
5. *Whether cost-sharing was appropriately calculated for claims for ancillary services provided by an out-of-network provider at an in-network facility.*

External review is not available for any other types of denials, including if your claim was denied due to your failure to meet the requirements for eligibility under the terms of the Plan. There is no cost to you to request an external review. The Plan assumes responsibility for fees associated with External Reviews outlined in this document.

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

(1) External Review of Standard Claims

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

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

(i) You are/were covered under the Plan at the time the health care item or service is/was requested or, in the case of a retrospective review, were covered under the Plan at the time the health care item or service was provided;

i. The Adverse Determination satisfies the above-stated requirements for external review and does not, for example, relate to your failure to meet the requirements for eligibility under the terms of the Plan.

(iii) You have exhausted the Plan's internal claims and appeals process (except, in limited, exceptional circumstances when under the regulations the claimant is not required to do so); and

(iv) You have provided all of the information and forms required to process an external review.

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

(i) If your request is complete and eligible for external review; or

(ii) If your request is complete but not eligible for external review, in which case the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free number 866-444-EBSA (3272)).

(iii) If your request is not complete (incomplete), the notice will describe the information or materials needed to complete the request, and allow you to perfect (complete) the request for external review within the four (4) month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

d. Review of Standard Claims by an Independent Review Organization (IRO). If the request is complete and eligible for an external review, the Plan will assign the request to an IRO. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the claim is assigned to an IRO, the following procedure will apply:

(i) The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your claim (generally, you are to submit such information within ten (10) business days).

(ii) Within five (5) business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

(iii) If you submit additional information related to your claim to the IRO, the assigned IRO must, within one (1) business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one (1) business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

(iv) The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO decision is not contrary to the terms of the Plan, unless the terms are inconsistent with applicable law. The IRO also must observe the Plan's requirements for benefits, including the Plan's standards for clinical review criteria, medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) health care providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s).

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

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

claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

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

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

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

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

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

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

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

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

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

(2) External Review of Expedited Urgent Care Claims.

a. **<u>You may request an expedited external review if:</u>** 1) you receive an adverse Initial Claim Appeal Benefit Determination that involves a medical condition for which the timeframe for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or 2) you receive an adverse Appeal Claim Benefit Determination that involves a medical condition for which the timeframe for completion of a standard external review would seriously jeopardize your life or health or would jeopardize your ability to regain maximum function; or, you receive an adverse Claim Appeal Benefit Determination that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from a facility.

b. **<u>Preliminary Review for an Expedited Claim.</u>** Immediately upon receipt of the request for expedited external review, the Plan will complete a preliminary review of the request to determine whether the requirements for preliminary review are met (as described

under Standard claims above). The Plan will immediately notify you (e.g., telephonically, via fax) as to whether your request for review meets the preliminary review requirements, and if not, will provide or seek the information (also described under Standard Claims above).

c. **Review of Expedited Claim by an Independent Review Organization (IRO).** Following the preliminary review that a request is eligible for expedited external review, the Plan will assign an IRO (following the process described under Standard Review above). The Plan will expeditiously (e.g., meaning via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the assigned IRO all necessary documents and information that it considered in making its Adverse Determination.

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

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

The IRO will provide notice of their final expedited external review decision, in accordance with the requirements set forth above under Standard Claims, as expeditiously as your medical condition or circumstances require, but in no event more than seventy-two (72) hours after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within forty-eight (48) hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

(i) If the IRO's final external review reverses the Plan's Adverse Determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed claim. However, even after providing coverage or payment for the claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.

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

For Kaiser HMO enrollees, please contact Kaiser or refer to the Kaiser evidence of coverage booklet for its own External Review Process as it relates to No Surprise Act covered items and services.

F. TEMPORARY PUBLIC HEALTH EMERGENCY EXTENSION RULES.

Effective immediately, an emergency regulation jointly released by the Internal Revenue Service ("IRS") and Department of Labor ("DOL") requires the Plan to disregard the period from March 1, 2020, until sixty (60) days after the announced end of the National Emergency or another date determined by the agencies in a future notice (referred to as the "Outbreak Period") for all Plan Participants, Beneficiaries, or Claimants when determining the periods and dates referenced in this section, **but the extended deadline will terminate the earlier of (1) One year from the date an individual is first eligible for the relief or (2) the end of the Outbreak Period, but in no event will an extended relief exceed One (1) year**:

1. **COBRA Qualifying Event Notice.** For Qualifying Events or receipts of the notice of COBRA continuation coverage occurring on or after March 1, 2020, the 60-day period to give a Qualifying Event Notice is temporarily extended and will terminate the earlier of: (1) one year from the date you (or your Dependents) were first eligible for an extended deadline or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. Please contact the Trust fund Office to determine your individualized situation.

2. **COBRA Premium Payments (For Initial Payment and Ongoing Monthly Payments).** If COBRA coverage is first elected during the Outbreak Period, all monthly premium payments for all months for which coverage is elected are temporarily extended. This means if COBRA coverage is first elected during the Outbreak Period, your initial COBRA payment is temporarily extended and will be due the earlier of: (1) one year from the date an individual is first eligible for the extended relief (calculated from 45 days from the date of your COBRA Election) or (2) the end of the Outbreak Period (but in no event will your extended relief exceed One (1) year. For all ongoing monthly premium payments for which coverage is elected, coming due during the Outbreak Period are also temporarily extended and will be due the earlier of: (1) one year from the date an individual is first eligible for the extended relief (plus 30 days because the premium payment is considered timely pursuant to the COBRA statute if paid within 30 days of the due date) or (2) the end of the Outbreak Period (but in no event will your extended relief exceed One (1) year. Please contact the Trust fund Office to determine your individualized situation.

3. **COBRA Election Notice.** A Qualified Beneficiaries 60 day right to elect COBRA upon receipt of the COBRA Notice is temporarily extended and will terminate the earlier of: (1) one year from the date an individual is first eligible for the extended relief (calculated from the later of the date you are furnished the election notice or the date you lose coverage) or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. Please contact the Trust fund Office to determine your individualized situation.

4. **Special Enrollment Rights.** For Participants that experience a birth, marriage or adoption as of March 1, 2020, their 30-day period to special enroll an eligible Dependent in the Plan upon birth, marriage, or adoption has been temporarily extended and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will your extended relief exceed One (1) year. If you or your Dependent lose coverage under CHIPRA or Medicaid as of March 1, 2020, you or your Dependents 60-day period to special enroll in the Plan (subject to meeting the Plan's eligibility rules) upon a loss of CHIPRA or Medicaid coverage has been extended. and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will your Dependent's extended relief exceed One (1) year. Please contact the Trust fund Office to determine your individualized situation.

5. **Plan's Claims Filing Procedure.** Any benefit claims filing requirements (including the 1-year period to file suit from the date you receive a denial of an appeal or adverse action), for claims as of March 1, 2020, has been temporarily extended and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. If applicable, for those claims received/processed prior to March 1, 2020, any days that passed prior to the March 1, 2020, start date of the Outbreak Period will not be disregarded in determining a claim filing deadline but the days that fall within the Outbreak Period will be temporarily tolled pursuant to federal guidance Please contact the Trust fund Office to determine your individualized situation.

6. **Plan's Appeals Procedure.** For those claimants (or their authorized representatives) who received an adverse benefit determination/claims denial as of March 1, 2020 the claimant (or authorized representative's) right to file an appeal within 180 days for health & welfare and disability-related claims has been temporarily tolled and will terminate the earlier of: (1) one year from the date the individual was first eligible for the extended relief or (2) the end of the Outbreak Period but, in no event will you (or your Dependent's) extended relief exceed One (1) year. If applicable, for those who received an adverse benefit determination or claims denial earlier than March 1, 2020, any days that passed prior to the March 1, 2020 start of the Outbreak Period will not be disregarded in determining your appeals filing deadline but the days that fall within the Outbreak Period will be temporarily tolled pursuant to federal guidance. Please contact the Trust Fund Office to determine your individualized situation.

IX. Patient Protection and Affordable Care Act

A. GRANDFATHERED PLAN.

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

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

B. NO PRE-EXISTING CONDITION EXCLUSIONS FOR ANY INDIVIDUAL.

The ACA prohibits insurance plans in the individual and group markets from imposing pre-existing condition exclusions on any individual for Plan Years beginning after January 1, 2014. This ban includes both benefit

limitations (e.g., an insurer or employer health plan refusing to pay for chemotherapy for an individual with cancer because the individual had the cancer before getting insurance) and outright coverage denials (e.g., when the insurer refuses to offer a policy to the individual because of the individual's pre-existing medical condition). This Plan does not impose any pre-existing condition exclusions as prohibited under federal law.

C. DEPENDENT CHILD COVERAGE THROUGH AGE 25.

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

D. INDIVIDUAL MANDATE (State requirement) & MINIMUM ESSENTIAL COVERAGE.

Minimum Essential Coverage Requirement (FEDERAL). The ACA establishes a minimum value standard of benefits for health plans and requires employers to provide minimum essential coverage. Minimum value means coverage under a health plan (such as this Plan) meets the minimum value standard if the plan's share of the total allowed costs of benefits provided is 60% or greater. Minimum essential coverage includes jointly-sponsored multiemployer group health plan coverage such as this Plan. The Board of Trustees believes this Plan provides minimum essential coverage and meets the minimum value standard for the benefits it provides.

Individual Mandate (STATE Requirement). Please note, California has its own minimum essential coverage reporting and individual mandate obligations that began on or after Jan. 1, 2020. This means California requires its residents unless an exception is met to have health coverage that qualifies as Minimum Essential coverage or pay a penalty for noncompliance. As indicated above, the Board of Trustees believe this Plan provides Minimum Essential Coverage to you and your eligible dependents. Depending on which coverage option you are enrolled in, for your California Individual Tax reporting purposes, the insured carrier (ex. Kaiser) will send you the applicable Form 1095-B statements to satisfy your California tax reporting obligations for maintaining minimum essential coverage and the Trust Fund Office will send you the applicable Form 1095-B statements to satisfy your California tax reporting obligations for the self-funded PPO Plan. Please contact Kaiser or the Trust Fund Office for the health option you are enrolled in for a copy of the Form 1095-B statement if you haven't already received one.

E. AVAILIABILITY OF SUMMARY OF BENEFITS & COVERAGE.

The ACA requires group health plans and health insurers to provide a Summary of Benefits and Coverage, also known as the "SBC", to Participants and their Dependents. The SBC is a standard format, written in easy-to-understand language, summary of what the Plan covers and what it costs. It is intended to help you understand and compare the different benefits and coverage options available to you under the Plan. Under the ACA, you also have a right to request and receive **within 7 business days** a copy of the Plan's SBC in paper form, at any time and free of charge. If you want a copy of the Kaiser HMO Plan SBC, please contact Kaiser Permanente at 800-464-4000. For a copy of the Plan's Self-funded PPO SBC, please contact the Trust Fund Office at 408-288-4400.

F. ELIMINATION OF LIFETIME & ANNUAL LIMITS ON ESSENTIAL HEALTH BENEFITS.

The ACA prohibits both grandfathered and non-grandfathered health plans from imposing lifetime and annual dollar limits on Essential Health Benefits. In accordance with the requirements of the ACA, this Plan does not impose any lifetime and annual dollar limits on its Essential Health Benefits. However, the Plan is permitted to impose annual limits on certain non-Essential Health Benefits consistent with the ACA and lawful

regulations issued thereunder. Non-Essential Health Benefits means benefits that are not Essential Health Benefits as determined by the Plan and Claims Administrator in its sole discretion. (Please refer to Article J. Section 29 for a definition of Essential Health Benefits.)

G. CERTIFICATES OF CREDITABLE COVERAGE NO LONGER REQUIRED.

Effective December 31, 2014, Insurers and Group Health Plans are no longer required to provide a Certificate of Creditable Coverage upon termination of your health coverage.

H. PROHIBITION ON RESCISSIONS.

Under the ACA, group health plans and insurers must not rescind coverage (meaning cancel or discontinue coverage retroactively) unless a covered individual commits fraud or makes an intentional misrepresentation of material fact. However, a retroactive cancellation or discontinuance of coverage is not a rescission if it: has only prospective effect; is initiated by the covered individual; due to delay in administrative record-keeping; termination of coverage retroactive to the divorce if a plan does not cover former spouses; or attributed to a failure to timely pay required premiums or contributions toward the cost of coverage. In accordance with the ACA, this Plan will not rescind coverage unless permitted by the ACA or you and/or your eligible dependent commits fraud or makes an intentional misrepresentation of material fact.

I. ACA NONDISCRIMINATION

It is the intention of the Board of Trustees and the contracted Insurers/HMO (ex. Kaiser Permanente and Anthem Blue Cross) that the Plan's benefits be provided in compliance with the requirements of the Affordable Care Act Section 1557 Non-discrimination rules. The Plan complies with the ACA Non-discrimination rules (including applicable Federal civil rights laws) and does not discriminate on the basis of race, color, national origin, age, disability, or sex nor does the Plan exclude people or treat them differently because of their race, color, national origin, age, disability or sex. The self-funded PPO Plan and Kaiser HMO Plan covers maternity benefits for eligible Dependent Children up to age 26 and also covers transgender services determined to be medically necessary by a licensed physician under the self-funded PPO Plan. (Please see section on Transgender Benefits for more information).

XX. GENERAL PROVISIONS

A. ACTS OF THIRD PARTIES/RIGHT OF RECOVERY/SUBROGATION.

This Plan does not cover any illness, injury, disease or other condition for which a Third Party is or may be liable or legally responsible by reason of negligence, an intentional act or breach of any legal obligation on the part of that Third Party. Charges and/or expenses incurred by a Participant or Dependent for which a Third Party is liable or responsible are not covered under any benefits provided in this Plan. However, if a Participant (including an eligible Dependent) is injured through the act or omission of another party, Plan benefits might be advanced only on the following conditions:

1. **Duty to Notify Trust Fund Office.** The Participant and/or Dependent agrees that as a condition precedent to being advanced any Plan benefits, the Participant or Dependent **will notify the Plan office within 30 days** if any claims incurred under the Plan are the result of an accident, injury, disease or

other condition for which a Third Party is or may be liable or legally responsible, by reason of negligence, an intentional act or breach of any legal obligation on the part of that Third party. The Participant and/or Dependent shall also immediately disclose to the Administrative Office all Recovery Funds and all settlements of any kind that have been obtained that are related to the Third-Party Claim including keeping the Plan informed at all times of the status of any recovering and settlement negotiations and filing of litigation;

2. **Agreement to Reimburse the Plan. Any Participant or Dependent who refuses to sign an Agreement to Reimburse and/or Assignment of Recovery in a form satisfactory to the Plan shall not be eligible for Plan benefit payments related to the injury involved**. Any Participant or Dependent who receives benefit payments and later fails to reimburse the Plan as set forth above will be ineligible for any future Plan benefit payments until the Plan has withheld an amount equal to the amount which the employee or dependent has failed to reimburse, including reasonable interest on such unpaid funds.

3. **Plan's Right to Intervene in Legal Action.** By accepting benefit payments from the Plan, any Participant or dependent agrees that the Plan may intervene in any legal action brought against the third party or any insurance company, including the employee's own carrier for uninsured motorist's coverage. The Participant or Dependent shall furnish any information or assistance and execute any documents that the Board of Trustees or its delegates may require or request to facilitate enforcement of their rights under this Section.

4. **Hold Recovery Funds in Trust or Escrow Account.** The Participant and/or Dependent agrees to hold any Recovery Funds in a Trust or escrow account for the Plan up to the amount of Covered Charges the Plan paid or may pay for the Injury or Illness of a Covered Person that are related to the Third-Party Claim. The Plan shall be paid first from the Recovery Funds. The Plan's reimbursement, restitution and subrogation rights shall extend to any property (including money) that is directly or indirectly in any way related to the Plan benefits involving the Third-Party Claim.

5. **Reimbursement/Repayment from Recovery Proceeds.** The Participant and/or Dependent (including its guardian, attorney or estate) will be required to pay or reimburse to the Plan or any entity providing benefits (such as Kaiser or Self-Funded Plan) immediately (when recovery is made) any proceeds received by way of judgment, settlement or otherwise (including receipt of proceeds under any uninsured motorists coverage, no-fault coverage, or other insurance including the Participant or Dependent's own or family insurance coverage) arising out of any claims for damages by the individual or his or her heirs, parents or legal guardians, to the extent of the payments made or to be made by the Plan for which the Third Party may be responsible, regardless of how it is classified or characterized;

6. **Present Assignment of Rights Against Third Party or Respective Insurers.** Any Participant or Dependent who accepts payments from the Plan agrees that by doing so he or she is making a present assignment of his or her rights against such third party (or their respective insurers) to the extent the payments made by the Plan. These rules are automatic, but the Plan may require that any participant or dependent sign an Agreement to Reimburse and/or Assignment of Recovery in such form or forms as the Plan may require;

7. **Grant Equitable Lien and/or Constructive Trust.** The Participant and/or Dependent grants the Plan an equitable lien and/or constructive Trust to all Recovery Funds up to the amount of Covered Charges the Plan paid or may pay for the Injury or Illness of a Participant or Dependent that are related to the Third-Party Claim. If the Participant or Dependent is represented by an attorney, all Recovery Funds shall be deposited in the attorney's Trust account. No portion of the Recovery Funds shall be paid to the Participant or Dependent, the attorney or anyone other than the Plan until the Plan 's right to

reimbursement has been fully satisfied. The lien may be filed with the third party, the third party's agents, or the court and the lien shall exist without regard to the identity of the property's source or holder at any particular time or whether at any particular time the property exists, is segregated, or whether the covered person has any rights to it.

8. **Plan Entitled to First Priority Recovery.** The Plan is entitled to a first priority recovery from the Recovery Funds for the full amount of Covered Charges it has paid or may pay for the Injury or Illness of a Participant and/or Dependent that are related to the Third-Party Claim. The first priority rights and repayment obligation exists regardless of whether: (i) a Participant and/or Dependent has been made whole; (ii) the Third Party admits liability or asserts that a Participant and/or Dependent is also at fault; (iii) a Participant and/or Dependent only sought the recovery of non-economic damages; (iv) a worker's compensation claim has been resolved through a disputed claims settlement where the parties agree the Injury or Illness is not work-related; or (v) Participant and/or Dependent recovers his full damages and/or attorneys' fees. The Board of Trustees reject the make whole, collateral source and common fund theories and the Plan 's rights shall not be affected by similar doctrines or rules, whether established at common law or statute, that would reduce the Trust's right to full recovery under this Subrogation and Reimbursement Obligations section of the Benefit Booklet.

9. **IMPORTANT! Your Failure to Comply with the Plan's Rights.** The Plan may, at the discretion of its Board of Trustees, suspend payment or deny payment (or offset the amount which should have been reimbursed against any future benefit payments that may otherwise be payable under the Plan to a Covered Person) of Covered Charges for an Injury or Illness of a Covered Person related to the Third Party Claim if a Covered Person and/or his/her attorney fail to cooperate and/or perform all acts required by this Subrogation and Reimbursement Obligations section of the Benefit Booklet or the Board of Trustees has a reasonable basis to believe a Covered Person will not honor all of his/her obligations under this Subrogation and Reimbursement Obligations section of the Benefit Booklet.

10. **IMPORTANT! If you Settle Without Authorization from the Plan or Interfere with the Plan's Rights.** If the Participant or dependent settles or compromises a third party liability claim in such a manner that the Plan is reimbursed in an amount less than its lien, or which results in a third party or its insurance carrier being relieved of any future liability for medical costs, then the Participant or dependent shall receive no further benefits from the Plan in connection with the medical condition forming the basis of the third party liability claim unless the Board of Trustees or its duly authorized representative has previously approved the settlement or compromise, in writing, as one which is not unreasonable from the standpoint of the Plan. The Participant and Dependent also agrees not to take action that may prejudice or interfere with the Plan's rights under this Section.

11. **Board and Its Authorized Delegates Authority.** The Board of Trustees or its authorized delegates have the authority to compromise and settle subrogation and reimbursement claims on a case-by-case basis depending on the facts and circumstances. While the Plan's Subrogation rights include the right to file an independent legal action or alternative dispute resolution proceedings against such Third Party or to intervene in one brought by or on the Participant or Dependent's behalf, it has no obligation to do so.

12. Participant and/or Dependent agrees that the Trust Administrative Office, Plan and/or Board of Trustees may notify any Third Party or Third Party's representative or insurer of the Plan's recovery rights set forth in this Subrogation and Reimbursement Obligations section of the Benefit Booklet.

B. COORDINATION OF BENEFITS WITH OTHER PLANS.

Members of a family are often covered by more than one group health insurance plan. As a result, two or more plans are paying for the same claim. To help control costs, this Plan provides a Coordination of Benefits provision. This provision affects all of your different benefits under the Plan.

General Coordination of Benefits Rule: If a covered Participant or dependent is entitled to benefits from another plan, the HMOs, insurance companies or other entities likely have rules on which plan is primary or secondary and who pay first. You should consult with these entities to determine the rule. The benefits provided herein shall be paid in accordance with the standardized coordination of benefits provisions of the National Association of Insurance Commissioners.

You may not reject coverage under another Plan, HMO and/or insurance company and/or not enroll in such other Plan, HMO and/or insurance company and then expect this Plan to be primary with respect to payment of your benefits. The other Plan, HMO and/or insurance company would be primary (or you would be responsible for such claims/payments if they refuse such given your failure to enroll or action of un-enrolling).

C. CONSTRUCTION.

The validity of the Plan or any of its provisions will be determined under and will be construed according to ERISA and other federal law and, to the extent permissible, according to the laws of the State of California. This Plan is intended to be construed as a whole, but in the event any provision of this Plan is held illegal or invalid for any reason, such determination will not affect the remaining provisions of this Plan and the Plan will be construed and enforced as if said illegal or invalid provision had never been included.

D. NO VESTED RIGHT.

Nothing in this Plan shall be construed as giving Employees, retired or terminated Employees, Dependents or any other person a vested right to continued coverage under this Plan. The Trustees retain full authority to amend or terminate coverage at any time and/or to increase premiums.

E. FACILITY OF PAYMENT.

Any death benefit payable to a minor may be paid to the legally appointed guardian of the minor, or if there is no such guardian, to such adult or adults as have complied with the requirements of California or other applicable law for receipt of such benefit on behalf of the minor, after which the Plan shall have no further obligations with respect to such minor.

F. AVAILABLE ASSETS FOR BENEFITS.

Benefits provided by this Plan can be paid only to the extent that the Fund has available adequate resources for such payments. No contributing Employer has any liability, directly or indirectly, for such payments. No contributing Employer has any liability, directly or indirectly, for providing the benefits established hereunder beyond the obligation to make contributions and other changes as required in the Collective Bargaining Agreement, if applicable.

In at any time the Fund does not have sufficient assets to permit continued payments hereunder, nothing contained in this Plan shall be construed as obligating any contributing Employer or any IBEW Local to make benefit payments or contributions in order to provide for such benefits. Likewise, there shall be no liability upon the Board of Trustees, individually or collectively, or upon any contributing Employer, the Union, signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Fund does not have sufficient assets to make such benefit payments.

G. INCOMPETENCE OR INCAPACITY.

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

H. GENDER AND NUMBER.

Whenever any words are used in this Plan in the masculine gender, they should be construed as though they were also used in the feminine gender and the singular the plural where they would so apply.

I. CLAIMS AND APPEALS PROCEDURE FOR SELF-FUNDED PLAN.

1. General Rules: The Claims and Appeals procedures set forth below apply only to the Self-funded medical, mental health/substance use disorder, Hearing Aid, and prescription drug benefits. Claims and appeals for insured benefits are governed by the rules of the specific insurance companies and Health Maintenance Organizations ("HMO"). Copies of the applicable claims and appeals procedures for the HMO medical plan, Vision and Dental claims are available directly from Kaiser Permanente, Delta Dental and VSP.

Under the procedures set forth in the Plan and as is required by ERISA, if your claim for health and welfare benefit is denied in whole or in part, you will receive a written explanation including the specific reasons for the denial. You will be notified in writing of such denial within the time frames indicated in Subsection 2 below.). An extension of time may be required in special circumstances. For all other claims that are not disability or group health plan related, you will be notified in writing of such denial within 90 days after receipt of such application or claim (in most situations, much earlier than 90 days). In many situations, there are delays because of information required by the Plan Office to process an application (such as a birth certificate and/or marriage certificate). You then have the right to have the Board of Trustees review and reconsider your claim. If you have a question regarding the Plan or your benefit, you have the right to submit a letter to the Plan office seeking a courtesy response. The Plan will generally respond within a timely manner (within thirty days unless an extension is required).

You have 12 months from the date of service to submit your proof of claim. In certain circumstances, the time frame for submitting your claim may be extended or delayed under contractual requirements that may exist between Anthem Blue Cross and a Preferred Provider, Medicare or other organization (if applicable). Specifically, the time period in such cases may be extended or delayed where a contract provider, Medicare or other organization (if applicable) has an agreement that allows for a longer period to file a claim with the Trust and the contract provider. Medicare or other organizations can demonstrate with satisfactory proof that the claim submission date complies with the terms of its respective agreements and/or law.

A claim is defined as any request for a Plan benefit made by a claimant or by an Authorized Representative of a claimant, that complies with the Plan's reasonable procedure for making benefit claims. Casual inquiries about benefits or circumstances under which benefits might be paid are not considered claims. Nor is a request for a determination of whether an individual is eligible for benefits under the Plan considered to be a claim. However, if a participant files a claim for a specific benefit and the claim is denied because the individual is not eligible under the terms of the Plan, the coverage determination is considered a claim.

Time limits imposed on the Plan are maximum times and begin with the receipt of the Claim without regard to whether the information necessary to make a benefit determination accompanies the filing. In the event that the period of time is extended due to a claimant's failure to submit information necessary to decide a Claim, the period for making the benefit determination shall be suspended from the date on which the notification of the extension is sent to the Claimant until the date on which the Claimant or his/her authorized representative responds to the request for additional information.

Time limits imposed on the Covered Person are minimum times and may be extended by the Plan (of by contract with the Preferred Provider). Time limits for furnishing additional information to the Plan begin when the claimant receives the request for additional information.

Notice of Adverse Benefit Determination or Denial Notice. It is required that the Plan provide you with specific reasons for denial of benefits and that you be given the opportunity for "full and fair review" of the denial from the provider of service (carrier). Any reference to "you" in includes you and your Authorized representative. An Authorized Representative is a person you authorize, in writing, to act on your behalf. The Plan will also recognize a court order giving a person authority to submit claims on your behalf. The Denial Notice will include the following:

a. The specific reason(s) for the denial;
b. The specific reference to pertinent plan provisions (as applicable) on which a denial is based;
c. A description of any additional material or information is necessary to support your claim, and an explanation of why such material or information is necessary;
d. Description on the steps to be taken if you wish to submit your claim for review/appeal and applicable time limits and a statement of your right to bring suit under ERISA Section 502(a) following your appeal;
e. If an internal rule, guideline or protocol was relied upon in deciding the claim, a statement that a copy is available upon request at no charge;
f. If the determination was based on the absence of Medical Necessity, or because the treatment was Experimental or Investigational, or other similar exclusion, a statement that an explanation of the scientific or clinical judgment for the determination is available upon request at no charge; and
g. For Urgent Claims, a description of the expedited review process (for urgent claims, the notice may be provided orally and followed with written notification).

You have at least 180 days (or longer if your plan agrees) to submit your claim for review.

2. <u>Denial (Claims Timeframes)</u>: A decision must be made on your initial request for a plan benefit as follows:

a. <u>Urgent Claims.</u> Claims for urgently needed care must be ruled on "as soon as possible", and in no event more than 72 hours after the claim is filed. The Plan will determine whether a claim is Urgent by applying the judgment of a prudent layperson that possesses an average knowledge of health and medicine. Alternatively, if a physician with knowledge of the patient's medical condition determines that the claim is Urgent, and notifies the Plan of such it will be treated as an Urgent Claim. If an Urgent Claim is received without sufficient information to determine whether, or to what extent, benefits are covered or payable, the Plan will notify you as soon as possible but not later than 24 hours after receipt of your claim of the specific information needed to complete its review of your claim. You must then provide the specified information within two (2) business days. If the information is not provided within that time, the claim will be denied. During the period in which you are allowed to supply additional information, the normal deadline for making a decision on the urgent claim is suspended from the date of extension notice until the earlier of either two (2) business days or the date you respond to the request. A decision will then be provided by the earlier of no later than 48 hours after receipt of the specified information or the end of the (2) two business day period given;

b. **Pre-Service Claims.** Claims for pre-approval or pre-authorization benefits must be decided upon within 15 days; and

c. **Post-Service Claims**. Claims for reimbursement when you have already received care must be ruled on within 30 days. This period may be extended one time for up to 15 days if necessary due to matters beyond the control of the Plan. If an extension is necessary, you will be notified before the end of the initial 30-day period, of the circumstances requiring an extension and the date by which the Plan expects to render a decision.

3. Disability Claims: A Disability Claim must be submitted to the Plan office within 90 days after the date of the onset of the disability. Decisions on disability claims and appeals have different time periods. If the Plan denies your application for disability benefits, the Plan will notify you of the denial within 45 days after the Plan's receipt of your application or claim (with two potential 30-day extensions).

An extension of time no exceeding 30 days may be necessary due to matters beyond the Plan's control. If a decision cannot be rendered due to matters beyond the control of the Plan prior to the expiration of the 30-day extension, the period for making a determination may be extended for up to an additional 30 days, in which event notice will be sent to you prior to the expiration of the first 30-day extension.

The notice of extension will include in addition to the information set forth above, the standards on which entitlement to a benefit is based; the unresolved issues that prevent a decision on the claim and the additional information needed to resolve those issues. You will be afforded at least 45 days to provide the specified information, if any. The deadline for the Board of Trustees to render its decision is tolled from the date on which the notification of the extension is sent to you until the date a response from you is received.

The denial notice of a disability claim should include the same information as that set forth above pertaining to non-disabled claims.

4. Appeal: If the application for benefits or a claim is denied or if you disagree with the decision made on the claim (including disability claims), you may petition the Board of Trustees for review of the decision (an appeal). Your appeal must be filed with the Plan **within 180 days** of your receipt of the denial notification. However, in certain circumstances the time frame for submitting your appeal may be extended under contractual requirements that may exist between Anthem Blue Cross and a Preferred Provider, Medicare or other organization (if applicable). Specifically, the time period in such cases may be extended where a contract provider, Medicare or other organization has an agreement that allows for a longer period to file an appeal with the Trust and the contract provider, Medicare or other organization can demonstrate with satisfactory proof that the appeal submission date complies with the terms of its respective agreements and/or law. You may have access to relevant documents, records and other information, including any statement of policy or guidance with respect to the Plan concerning the denied treatment option or benefit for your diagnosis, without regard to whether such advice or statement was relied upon in making the benefit determination.

Your appeal of the adverse benefit determination of your claim will be decided at the next regularly scheduled meeting of the Plan's Board of Trustees following the Plan's receipt of your appeal, unless the appeal was received within 30 days prior to the date of the Board meeting. If that occurs, the appeal must be decided by the following regularly scheduled Board meeting. If special circumstances require a further extension of time for processing, the Plan office will provide you with a written notice of the extension, describing the special circumstances and the date as of which the determination will be made.
If your Appeal is denied, your Appeal Denial Notice will explain:

a. The Reasons for the denial, including references to pertinent Plan provisions (as applicable) upon which the denial was based;
b. Your right to receive, upon request and free of charge, reasonable access to and copies of all relevant documents, records, and other information (other than legally or medically privileged documents) to your claim for benefits; and
c. Your right to bring a civil action under ERISA section 502(a).

5. Finality of Decision on Claim – Right to File Lawsuit: The denial of an application or claim after the right to review has been waived or the decision of the Trustees on appeal has been issued is final and binding upon all parties, including the claimant. No lawsuit may be filed without first exhausting the above appeals procedure. No legal action may be commenced or maintained against the Plan or any Trustee or legal fiduciary, person or entity involved in the decision more than one (1) year after a claim has been denied on appeal.

6. When a Lawsuit May be Started: No Participant, Dependent, Beneficiary or other person shall have any right or claim to benefits under these Rules and Regulations or any right or claim to payments from the Fund, other than as specified herein. A Participant may not start a lawsuit to obtain benefits until after either: (1) the Participant has submitted a Claim pursuant to these Rules and Regulations, requested a review after an Adverse Benefit Determination, and a final decision has been reached on review; or (2) the appropriate time frame described above has elapsed since Participant filed a request for review and Participant has not received a final decision or notice that an extension will be necessary to reach a final decision.

No lawsuit may be filed (started) more than one (1) year after services were provided or benefits partially of totally denied or an otherwise adverse determination was made against you (or your authorized representative) or, if the Claim is for short term disability benefits, more than one (1) year after the onset of the disability. The provisions of this Section shall apply to and include any and every claim to benefits from the Fund, and any claim or right asserted under the Plan or against the Fund, regardless of the basis asserted for the claim, and regardless of when the act or omission upon which the claim is based occurred, and regardless of whether or not the claimant is a "Participant" or "Beneficiary" of the Plan with the meaning of those terms as defined in ERISA. Such claim shall be limited to benefits due to him under the terms of the Plan, or to clarify his rights to future benefits under the terms of the Plan, and shall not include any claim or right to damages, either compensatory or punitive.

7. Lawsuit Filed in Northern District of California/No Participation in Class Action Lawsuits:

(a) Choice of Venue Limit. If there is a lawsuit, the participant or beneficiary (or Authorized Representative) agrees to submit to the jurisdiction of the United States District Court for the Northern District of California and any such lawsuit has to be filed in the United States District Court, Northern District of California which shall be the exclusive venue of any such action or proceeding. The participant or beneficiary (or Authorized Representative) also irrevocably and unconditionally waives any objection that it might now or hereafter have to the venue of the aforementioned court and any claim that any action or proceeding brought in aforementioned court has been brought in an inconvenient forum.

(b) Class Action Waiver. Any person including participants and beneficiaries seeking benefits or otherwise challenging action or inaction of the Plan (such as questioning the Plan's investments), the Board of Trustees, a Trustee or other person or entity involved with any Plan action or omission is not permitted to participate in or bring a class action lawsuit as a member in any class or representative action against the Plan, the Board of Trustees, a Trustee or any other person or entity involved with any such Plan action or omission. Only individual lawsuits are permitted meaning any person including

participants and beneficiaries may only bring claims in its individual capacity, and not as a plaintiff or class member in any purported class or representative proceeding.

J. MISCELLANEOUS PROVISIONS.

Self-funded plan benefits shall be paid only if notice of a claim is made within 90 days from the date on which covered charges were incurred. The claimant must submit properly completed claim forms and itemized statements as authorized by the Board of Trustees. Any exceptions to the submission of the claims later than 90 days are subject to the approval of the Board of Trustees, but in no event may claims be considered for payment later than 15 months from the date on which covered charges were incurred.

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

No participant, dependent or other beneficiary shall have any right to claim to benefits form the Plan, except as specified. Any dispute as to eligibility, type, amount or duration of the benefits under this Plan or any amendment or modification thereof shall be resolved by the Board of Trustees. The Trustees shall have discretion in any such determination. Participants may seek review of any adverse decision of the Trustees in Federal District Court as prescribed by law.

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

The provisions of the Plan are subject to and controlled by the provisions of the Trust Agreement, if applicable, and in the event of any conflict between the provisions of the Trust Agreement and the provisions of this Plan, the Trust Agreement shall prevail. Certain benefits are self-funded and any references to "insurance" are inapplicable to Self-Funded benefits.

It is recognized that the self-funded benefits provided by the Plan can be paid only to the extent that the Fund has available adequate resources for such payment. No contributing employer, the Local Union nor any individual trustee or the Board of Trustees has any liability, directly or indirectly to provide the self-funded benefits established hereunder beyond the assets available in the Fund and the obligation of contributing employers to make contributions as stipulated in the collective bargaining unit agreements.

WARNING: BENEFITS CAN BE REDUCED OR ELIMINATED

The Board of Trustees reserve the right to reduce or modify any and all benefits of the Plan, in part or in whole, and may change or eliminate any or all insurance carriers, HMOs and any other provider or entity. The Board may also require contributions for any increases to the Plan from time to time from the Participants of the Plan. Any such changes are at the discretion of the Board of Trustees.

K. HEALTH REIMBURSEMENT ACCOUNT (HRA).

This Plan includes a Health Reimbursement Account (HRA) program for the benefit of eligible Participants and their Dependents. The purpose of the HRA program is to reimburse eligible participants and qualified dependents for certain qualified health care expenses which are not otherwise payable under the Plan. The HRA program under the Plan uses pre-tax dollars in the account to pay for qualified out-of-pocket health care expenses allowed under the Internal Revenue Code ("IRC"), and as defined below. Any pertinent rules of the IRC Sections 105 and 106, as amended, including relevant IRS regulations as applied to an HRA shall apply to this Plan. The Plan has contracted with **Navia Benefit Solutions** to help administer the reimbursements of eligible HRA expenses.

1. Eligibility: Each Active Participant who meets the Eligibility requirements under the Plan and for whom employer contributions are made under a Collective Bargaining Agreement for the purpose of a HRA (supplemental account) will be eligible to participate in the HRA program. Participants are not allowed to make additional employee contributions to their HRA.

In order to comply with the Patient Protection and Affordable Care Act, IRS Notice 2013-54, and EBSA Technical Release 2013-03 the following eligibility rules also apply:

a. In order to use the HRA for reimbursements, the Active Participant must be actually enrolled in this Plan or other group health plan that provides minimum value pursuant to the IRC Section 36B(c)(2)(C)(ii), regardless of whether the other group health plan is sponsored by the Green Health Trust Fund.
b. Proof of Other group health coverage will be required in a manner to be determined by the Joint Oversight Committee. If the Active Participant is not enrolled in this Plan and does not provide proof of enrollment in other group coverage that provides minimum value, in a manner determined by the Joint Oversight Committee, benefits from the HRA will be limited to reimbursement of co-payments, co-insurance, deductibles, and premiums, as well as medical care defined under the IRC section 213(d) that does not constitute essential health benefits.
c. Any Participant who has an HRA balance is permitted to permanently opt out of and waive future reimbursements from his or her HRA account on an annual basis.
d. Upon termination of employment, the Participant may elect to either forfeit his or her HRA balance or permanently opt out of and waive future reimbursements from his or her HRA.

2. Claim and Reimbursement Requests: To obtain a Reimbursement form or if you have questions about your HRA account, please contact the Plan Administrator at:

Navia Benefit Solutions
San Mateo Electrical Workers Health Care Plan
ATTN: HRA Claims Dept.
P.O. Box 53250
Bellevue, WA 98015

The Plan has contracted with Navia Benefit Solutions to help administer the reimbursements of eligible HRA expenses. Navia issues members a debit card to use in the alternative of submitting a claim for reimbursement. The Navia debit cards can only be used for eligible qualified expenses. IRS regulations require that all debit card transactions are substantiated and that improper use of the card will result in suspension of card privileges. If You, Your spouse, and/or Your Dependents are eligible for other group health coverage, You must include a copy of the Explanation of Benefits (EOB) from the other group health coverage as well as any EOB from this Plan. Only eligible expenses that have not been reimbursed, as shown on the EOB form, will be considered eligible for reimbursement.

You may submit eligible expenses for reimbursement at any time but any written claim form must be submitted timely (see paragraph below). While requests for reimbursement can be made at any time, to limit administrative expenses, **the Plan requires that any requests for reimbursement be for a minimum of $50**. Therefore, You will have to hold Your requests for reimbursement until You have at least $50 in eligible expenses. In addition, the amount reimbursed for any eligible expense will not exceed Your HRA balance at the time reimbursement is requested. However, in the event Your Plan coverage ends, You may submit eligible expenses totaling less than $50 to close out Your HRA.

Timely Submission of Proof of Claim. To receive reimbursement for eligible expenses, You must submit a written claim form (with supporting documents) within 12 months of the date the expense was incurred and in accordance with the Plan's claim procedures. If You fail to do so, Your claim may be denied. In addition, any HRA payments that are unclaimed (e.g., uncashed checks) by the end of the year following the year in which the claim was incurred, will remain the property of the Plan.

If you are using the Navia debit card you can access your HRA in three ways:

1. **Online Claim Submission Tool.** If you paid out of pocket and are requesting reimbursement you can use the Navia Online Claim submission tool at https://www.naviabenefits.com.
2. **MyNavia App.** You can use the MyNaviaApp to submit claims right through your mobile phone. Just enter your claim information and upload a photo of your documentation from your phone's camera.
3. **Email.** Fill out a claim form, attached your itemized documentation and then email it to claims@naviabenefits.com.

Reimbursement applications must be accompanied by a signed statement verifying that the eligible expenses:

- Have not been otherwise reimbursed, nor will they otherwise be reimbursed, through any other source (including a Health Care FSA, if applicable);
- For premiums paid for other coverage, have not been paid or are not eligible for payment on a pre-tax basis; and
- Have not been taken, nor intend to be taken, as a tax deduction.

Along with the form, You must provide any of the following, as applicable:

- An itemized bill from the service Provider that includes the name of the person incurring the charges, date of service, description of services, name of Provider, and amount of charge.

- An Explanation of Benefits (EOB) from any coverage (including any EOB from this Plan) when requesting reimbursement of the balance of charges for which coverage is available plus original receipts verifying payment.
- Proof of the amount and date paid when requesting reimbursement for other insurance premiums, such as a spouse's group health coverage premiums and verification that the premium was not paid or eligible for payment under an IRC Section 125 Plan. Additional documentation is also required for reimbursement of premiums under a qualified long-term care contract.
- A receipt and proof of purchase or rental for covered items (such as for crutches or wheelchairs).
- Any additional documentation requested by the Plan.

HRA benefits are intended to pay benefits only for medical care expenses not previously reimbursed or reimbursable elsewhere. If a medical care expense is payable or reimbursable from another source, that other

source will pay or reimburse before payment or reimbursement from the HRA. However, if the eligible expense is covered by both the HRA and by a health care Flexible Spending Account (FSA), then the HRA is not available for reimbursement of that expense until after amounts available for reimbursement under the FSA have been exhausted.

3. Qualified Expenses: An Active Participant or Qualified Dependent under the Internal Revenue Code who is eligible for benefits under this Plan may be reimbursed from his or her HRA for any Qualified Expenses that are not otherwise covered by the Plan (see below). To qualify for payment through an HRA, the following requirements must be met:

a. Expense must be "Qualified Expense" as defined in in IRC Section 213(d). **For a complete list please view the IRS publication at *http://www.irs.gov/pub/irs-pdf/p502.pdf***. For example, below is a list of some examples (not an all-inclusive list) of Qualified Expenses which are reimbursable if not otherwise covered by the Plan:

Abdominal Supports	*Gum Treatment*	*Acupuncture*	*Air Conditioner*
Alcoholism Treatment	*Abortion*	*Anesthetist*	*Arch Supports*
Artificial Limbs	*Ambulance*	*Blood Tests*	*Blood Transfusions*
Braces	*Birth Control Pills*	*Chiropractor*	*Childbirth/Delivery*
Diagnostic fees	*Cardiographs*	*Prescriptions*	*Eye Glasses*
Blood Tests	*Drug Addiction Therapy*	*Gynecologist*	*Vaccines*
Blood Transfusions	*Oral Surgery*	*Insulin*	*Wheel Chair*
Hospital Bills	*Lab Tests*	*treatment*	*Splints*
Hearing Aids	*Pediatrician*	*Psychiatrist*	*Registered Nurse*
Splints	*Hydrotherapy*	*Orthotic Shoes*	*Oxygen equipment*
Dermatologist	*Vitamins (if prescribed)*	*Podiatrist*	*Lead paint removal*
Dental X-Rays	*Christian Science practitioner*	*Guide Dog*	

b. Expense must have been incurred while the Participant was covered by the Plan, regardless of when the claim is made.
c. The Expense must have been incurred by the participant or by a person who was a dependent within the meaning of the IRC section 152.
d. The Participant or dependent (if applicable) must provide documentation (ex. copy of the EOB or receipt that you receive showing the amount that you owe, the amount that you paid, the amount of eligible charges that were applied to the deductible, or a receipt along with the claim form), satisfactory to the Plan that the claim satisfies the requirements of this section. (Note: Credit card receipts, canceled checks, and balance forward statements do not meet the requirements of acceptable documentation).
e. The claim for reimbursement must be made within twelve (12) months of the time the expense was actually incurred.
f. Effective for expenses incurred on or after January 1, 2020, qualifying medical expenses reimbursable under the HRA pursuant to the Internal Revenue Code, include the following:

- Over-the-counter (OTC) medicines and drugs without a prescription and
- Menstrual care products (defined as tampons, pads, liners, cups, sponges and similar products used by the individual with respect to menstruation or other genital-tract secretions.).

13. Benefits are Not Vested/ No Cash Death Benefits: The Board of Trustees may amend, reduce, eliminate or otherwise change the HRA program at any time and may change, reduce, or discontinue any Plan

benefits, in whole or in part, at any time. No provision in these HRA rules shall be construed as making such HRA accounts vested at any time or subject to use in any manner except as provided for in these rules. There is no vested right to an HRA balance. In addition, pursuant to IRC guidelines, **no** cash death benefits are permitted under the Plan.

14. Forfeiture Provisions: An HRA balance will be immediately and permanently forfeited if either of the following applies to the participant and any amount forfeited will be used to offset administrative costs of the Plan's HRA program:

1. Upon your death, if you have no eligible surviving dependent(s) any unused balances in your HRA will be forfeited.
2. You accept employment in any capacity and of any duration from a contractor in the electrical industry who is not signatory to the memorandum of understanding/collective bargaining agreements.
3. The participant is an owner of a company, business, or entity in the electrical industry which is not signatory to a memorandum of understanding/collective bargaining agreement of an IBEW union having jurisdiction.

L. WELLNESS PROGRAM

This Plan includes a voluntary Wellness Program for the benefit of eligible Active & Early Retired Participants and their Dependent Spouse. Because the Wellness Program may provide or involves medical care, it is subject to the nondiscrimination rules and regulations under the Health Insurance Portability and Accountability Act ("HIIPAA), ERISA, the Patient Protection and Affordable Care Act ("PPACA"), and the Americans with Disability Act ("ADA"). The Plan has contracted with **BaySport, Inc.** to administer and provide services for this Plan's Wellness Program. The Wellness Program is being adopted to promote a healthier lifestyle, to lower the health care costs of the Plan and to keep you and your family healthy, and happy. While the Plan's provisions determine the programs, activities and events that the Plan provides, you and your health care provider have ultimate responsibility for determining appropriate treatment and care and whether you are able to participate in the Plan's programs, activities and events. The Plan is not responsible for any injury, loss or damage you may sustain as a result of your participation in the plan's program.

1. **Eligibility & Participation:** Each Active and Early Retired Participant and their Dependent Spouse who meets the Eligibility requirements under the Plan and are currently enrolled under the Group Health Plan are eligible for participation in the Wellness Program. Participation in the Wellness Program is voluntary. This means it is NOT mandatory to participate in this wellness program.

2. **Wellness Benefits:** By participating in the Plan's Wellness Program, you and your eligible Dependent will have access to health improvement programs including interactive tools, resources, information, and online resources (via *BaySport Wellintune* website and the *BaySport Clovi* application) to help you achieve and maintain a healthy, balanced lifestyle. For more detailed information on the current wellness benefits offered please contact the Trust Fund Office or BaySport office at 1-408-395-7300. You can also visit www.wellintune.com/go/ibew617 for details. The Wellness Benefits offered may include the following:

   Health Screening and Health Survey. Health Screenings may be conducted to help determine the risk of ongoing diseases early, when there is still a chance to treat or prevent them. These screenings may include blood pressure, blood sugar, cholesterol profile, height and weight body mass index (BMI) measurement and an individualized consultation. Also, a Health Survey or Questionnaire may be conducted to help you evaluate your health and identify potential health risks. The results of your Health Risk Assessment are confidential and are not available to the Plan, signatory employers or the union. However, the Plan may receive de-identified aggregate reports broken down by gender, metrics

and risk levels of the overall workforce. All of your personal health information ("PHI") is confidential. The Plan will comply with all federal and state rules and regulations, including the HIPAA Privacy rules in handling your PHI.

Flu Shots. BaySport may provide scheduling and delivery of flu shots to you and your eligible dependents. The location of the flu shots would primarily be at the IBEW Local 617 union office.

Health Coaching Program. The Health Coaching Program is an intensive lifestyle intervention (3 months) for high-risk individuals that include one-on-one consultant with a health coach and exercise and nutrition counseling (ex. in-person, phone and educational support via email). The program would also include a re-testing of risk factors to assess health improvement.

Ask the Nutritionist. Registered Dietitians will be available to provide face-to-face, telephonic, application-based text exchange, or e-mail services to target specific nutritional goals for program participants. Typical points for nutrition include weight loss, diabetes risk reduction, cardiovascular disease risk reduction, eating on the road, and health recipes. Please contact Patti Miller, RDN nutritionist at patti.miller@baysport.com for consultations to target your specific nutritional goals.

Injury Assessment Services. This program includes an individual assessment of an injury by a Board Certified Physical Therapist. Although no treatment will be offered during the visit, participants and eligible dependents will receive guidelines (ex. specific exercise recommendations, physical therapy plan, referral to a physician) to help them accomplish the fastest possible recovery and return to activity. These services are offered at one of the BaySport's clinic locations.

Incentive Programs. This benefit offers an incentive-tracking program where the Plan may recognize you and your eligible dependent for taking a more active role in your health and well-being (ex. pedometer program, weekly workout routines, survivor team challenge, fitness Olympics, team weight challenges). This benefit may reward you when you complete specific incentive activities. Please contact the Trust Fund Office for any current rewards implemented by the Board of Trustees. Please note rewards and incentives are subject to change.

Wellness Manager. BaySport has assigned a Wellness Manager to work with the Plan in providing five hours of weekly support and to be the day-to-day representative for the Plan's Wellness Program coordinator.

Health Fair. BaySport will hold ongoing health fairs to provide various vendors in the areas of health, recreation, injury management, sports and entertainment for the Plan. These fairs will be announced in advance of its proposed dates.

Below are some BaySport clinic locations available to you:

BaySport at Bay Club Redwood Shores 200 Redwood Shores Parkway Redwood City, CA 94065 rcoffice@baysport.com	BaySport Preventive Medicine Clinic 275 Battery Street, Suite 860 San Francisco, CA 94104 sfoffice@baysport.com
BaySport at Bay Club Santa Clara 3250 Central Expressway Santa Clara, CA 95051 scoffice@baysport.com	BaySport, Inc. 14830 Los Gatos Boulevard, Suite 101 Los Gatos, CA 95032 lgoffice@baysport.com

M. NO ASSIGNMENT TO PROVIDERS. There is no assignment of benefits to Providers and no benefit payments may be paid to Providers.

XXI. POTENTIAL LOSS/DELAYED PAYMENT OF BENEFITS

You and/or your eligible Dependent(s) could lose your benefits and/or have payments delayed in at least the following circumstances:

A. PLAN EXCLUSIONS/CO-PAYMENTS. The Plan and the insurance providers contain exclusions and exceptions for coverage. You should be aware of the Plan's and the insurance provider's limitations, exclusions, co-payments and other facets of the Plan in which you may not receive full payment on a claim or reimbursement or for which there is a co-payment.

B. INELIGIBLE FOR BENEFITS. The person on whose behalf the claim was filed was not eligible for benefits on the date the expenses were incurred.

C. NOT COVERED/NOT INCURRED. The expenses that were denied are not covered under the Plan or were not actually incurred.

D. FULL BENFIT PROVIDED. The Person for whom the claim was filed had already received the maximum benefit allowed for that type of expense during a stated period of time.

E. PROHIBITED EMPLOYMENT IN THE ELECTRICAL INDUSTRY. If you engage in certain kinds of work in the Electrical Industry, known as Prohibited Employment, you will no longer be entitled to Health and Welfare benefits.

F. SUBROGATION/THIRD PARTY CLAIMS. The Plan does not cover any illness, injury, disease or other condition or claim for which a third party may be liable or legally responsible.

G. COORDINATION OF BENEFITS WITH OTHER PLANS. If Dependents are covered by more than one Plan, this Plan may not be responsible for many claims.

H. WORK RELATED INJURIES. The Plan is not responsible for paying any claims incurred as a result of a work-related injury. This applies even if you have not filed a claim with workers compensation.

I. RIGHT TO RECOVER CLAIMS PAID or Offset of Future Claims/Recover Overpayments. The Plan has the right to recover any amounts improperly paid. The Plan may offset any amounts owed to the Plan against any claims that you and/or a Dependent incur in the future.

J. INADEQUATE OR IMPROPER EVIDENCE. The Plan grants the Board of Trustees the power to deny, suspend or discontinue benefits to a Participant who fails to submit at the request of the Plan Office any information or proof of coverage reasonably required to administer the Plan.

K. FAILURE TO ENROLL IN MEDICARE PARTS A AND B. If you are eligible for and fail to enroll in Medicare parts A and B the Plan will not pay many of your claims. Please refer to page 18, section B for additional information.

L. FAILURE TO COMPLETE APPLICATION. Benefits may not be payable until a completed application and other forms required by the Plan Office are received by the Plan Office.

M. INCOMPLETE INFORMATION/FALSE STATEMENTS. If you fail to provide requested information or give false information to verify disability, age, beneficiary information, marital status or other vital information, coverage under the Plan or benefits provided may be postponed or cancelled. If you make a false statement to the Plan or other officials regarding the payment of benefits or other issues related to the Plan, you will be liable to the Plan for any benefits paid in reliance on such false statements or information. This includes but is not limited to costs incurred by the Plan Office, reasonable attorneys' fees, and interest charges. The Plan may deduct any such fees and costs from any benefits otherwise payable to you, your estate or a beneficiary.

N. PLAN CHANGE. The Trustees amended the Plan's eligibility rules or decreased Plan benefits.

O. FAILURE TO MAKE EMPLOYER CONTRIBUTIONS. If the Contributing Employer did not make contributions on your behalf, you will not be eligible for Retiree Health and Welfare Coverage.

P. PLAN TERMINATION. If the Plan terminates, benefits will no longer be provided.

XXII. AMENDMENT AND TERMINATION OF THE PLAN

A. AMENDMENTS.

The Plan may be amended in whole or in part at any time by the Board of Trustees and all persons with rights or obligations hereunder shall be bound thereby. Benefit levels and amounts may be changed at any time.

B. MANDATORY AMENDMENTS.

Amendments of the Trust or Plan shall be mandatory in the following situations: When necessary to assure compliance with ERISA or other applicable laws; when necessary to assure the tax-deductibility of contributions hereto under federal and state income tax laws; and when necessary to assure that this Trust remains tax exempt.

C. TRANSFER OF ASSETS TO ANOTHER BENEFIT TRUST.

Notwithstanding anything above to the contrary, the Board of Trustees may transfer the Trust assets or any portion thereof to the Trustees of any other trust or trusts which provide similar benefits.

D. TERMINATION.

The Board of Trustees may terminate the Plan at any time subject to the Trust Agreement and applicable Collective Bargaining Agreements.

Upon termination of the Trust, all obligations shall first be satisfied. The Board of Trustees shall thereupon use the remaining Trust assets to provide Plan benefits in such manner as the Plan my provide, or in the absence of a Plan provision, to continue to provide Plan benefits in a manner permitted by ERISA for so long as Trust assets permit.

XXIII. GENERAL INFORMATION
(As required by ERISA)

1. **Name and Address of the Plan**: San Mateo Electrical Workers Health Care Benefits Plan, 6800 Teresa Boulevard, Suite 100, San Jose, California 95119.

2. **Type of Plan**: This is a partially Self-funded and HMO Insured jointly administered Multi-Employer Group Health Plan, providing the following Health Care Benefits Plan –Hospital, Surgical, Medical, Mental Health/Substance Abuse Benefits, Dental, Vision, Hearing, Disability, Life, AD&D and Employee Assistance Program coverage.

3. **Type of Plan and Method of Fund Benefits**: This Plan is administered by the Joint Board of Trustees. The Plan is funded by employer contributions as provided for in the collective bargaining agreement. Claims not related to HMO and insured providers are processed by a contract administrator.

4. **Sponsoring Organizations**: The Plan is maintained in accordance with collective bargaining agreements between N.E.C.A., San Mateo Chapter and Local 617 of the International Brotherhood of Electrical Workers Union. By writing to the Union, participants and beneficiaries may determine whether a particular employer is a sponsor of the Plan, and if so, the employer's address.

5. **Contributions**: Contributions to provide Plan benefits are paid by the sponsoring employers in accordance with their bargaining agreements "on a cents-per-hour basis".

6. **Plan Administrator**: The Board of Trustees is the Plan Administrator of the Plan. The Board of Trustees is responsible for ensuring that information regarding the Plan is reported to governmental agencies and disclosed to Plan Participants and beneficiaries in accordance with ERISA. The Plan Administrator's address is 6800 Teresa Boulevard, Suite 100, San Jose, California 95119.

7. **Fiscal Year**: The fiscal and Plan year of the Trust is the twelve-month period beginning June 1st to May 31st, and the Trust's records are maintained on that basis.

8. **Employer Identification Number**: 94-6077920

9. **Plan Number**: 501

10. **ERISA Rights**: As a participant in this Plan, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office all documents governing the Plan, including insurance contracts and collective bargaining agreements and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor, Internal Revenue Service and available at the Public Disclosure Room of the Employee Benefits Security Administration.
- 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 of some of these documents.

- 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 at no cost to the participant.
- Continued health care coverage for you and your spouse or dependents if there is a loss of coverage under the Plan as the result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this Summary Plan Description on the rules governing your COBRA continuation coverage rights.

In addition to creating rights for Plan participants, ERISA imposes duties upon the individuals who are responsible for the operation of the Employee Benefit Plan. The individuals who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries.

No one, including your employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining benefits under the plan or exercising your rights under ERISA. If your claim for benefits is denied or ignored, in whole or in part, you must receive a written explanation for the denial. You have the right to have the Plan review and reconsider your claim.

Under ERISA there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest summary 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 $110.00 per day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the Plan Administrator.

If you have a claim for benefits, which is denied or ignored, in whole or in part, and you have exhausted the administrative remedies available under the plan, you may file suit in a State or Federal Court. In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order or domestic relations order, you may file suit in Federal Court. If it should happen that Plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal Court.

The Court will decide who should pay the court costs and legal fees. If you are successful, the Court may order the person you have sued to pay these costs and fees. If you lose, the Court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

If you have any questions about the Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, 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, Pension and Welfare Benefits Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210.

You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the EBSA. For single copies of publications, contact the EBSA Brochure Request Line at (866) 444-3272 or contact the EBSA field office nearest you.

You may find answers to your questions and a list of EBSA offices at www.dol.gov/ebsa/welcome.html.

11. **Names and Addresses of the Board of Trustees**: Please contact the Administrator's office for the most up to date list of Trustees.

Employer Trustees	**Union Trustees**
William Kuhr, Chair	**Scott Wein, Co-Chair**

David Chad	**Dan Pasini**
Tim Lynch	**Dave Mauro**
Brian Iwashita	**Abe Talakai**
NECA, San Mateo Chapter 950 John Daly Boulevard Daly City, CA 94015 650-755-5014	**IBEW Local 617** 1701 Leslie Street San Mateo, CA 94402 650-547-4239

12. **Name and Address of Contract Administrator**:
United Administrative Services
6800 Santa Teresa Boulevard, Suite 100
San Jose, CA 95119
Phone (408) 288-4400
Sandy Stephenson, Fund Manager
E-mail: SStephenson@uastpa.com

13. **Name and Address of Agent for Service of Legal Process**:

Neyhart, Anderson, Flynn & Grosboll
Attn: Lois H. Chang & Richard K. Grosboll
Attorneys at Law
369 Pine Street, Suite 800
San Francisco, CA 94104-3323
Telephone: (415) 677-9440
E-mails: LChang@neyhartlaw.com & RGrosboll@neyhartlaw.com

XXIV. HIPAA Disclosure of Providers

In accordance with the new disclosure requirements of the Health Insurance Portability and Accountability Act, we are informing you of the names and addresses of all Heath Providers and/or Contracted Vendors for the Plan and their roles (i.e., whether they guarantee the payment of benefits or provide administrative services).

List of Providers

Anthem Blue Cross (Self-Funded PPO Plan Provider)
11030 White Rock Road
Rancho Cordova, CA 95670

Jointly administers health care benefits of the self-funded group health plan including but not limited to pricing claims, access to network provider services, utilization review, and managed care services.

Beat It! (Substance Abuse Benefits Provider)
1796 Technology Drive
San Jose, CA 95110

Provides Substance abuse or alcohol abuse, marital difficulty, financial, legal and other issues. Does not guarantee payment of these benefits.

Optum Health (Mental Health and EAP Provider)
160 W. Santa Clara Street
San Jose, CA 95113

Providers behavioral health and mental health services and Employee Assistance Program ("EAP") services through the self-funded plan. However, the EAP program is considered an excepted benefit and is separate program from the mental health and substance abuse benefits. Does not guarantee payment of these benefits.

Delta Dental (Dental & Orthodontic Benefits)
1333 Broadway, Suite 800, Oakland, CA 94612

Provides prepaid fully insured dental benefits with guaranteed payment of these benefits for eligible participants and dependents.

Kaiser Foundation Health Plan (Insured HMO Plan Provider)
1800 Harrison Street, 13th Floor
Oakland, CA 94120

Provides prepaid medical benefits with guaranteed payment of these benefits.

MetLife (Life and AD&D Benefits Provider)
P.O. Box 803323,
Kansas City, MO 64180-3323

Fully insures life and accidental death and dismemberment ("AD&D") benefits for eligible participants.

Sav-RX (Pharmacy Benefit Manager)
224 N. Park Avenue
Fremont, NE 68025

Providers prescription drug preferred provider networks, mail service pharmacies, utilization review, and general benefit information and inquiries for the self-funded group health plan.

Vision Service Plan (Vision Benefits Provider)
One Market Plaza
San Francisco, CA 94105
Phone: 1-800-877-7195

Provides fully insures vision benefits for eligible participants and dependents.

The Act also requires that we inform you of the U.S. Department of Labor address in Washington, D.C. If you have any questions about your rights under ERISA, you should contact the nearest office of the Employee Benefits Security Administration ("EBSA"), U.S. Department of Labor, listed in the telephone directory or the Division of Technical Assistance and Inquiries, EBSA, U.S. Department of Labor, 200 Constitution Avenue, N.W. Washington, D.C. 20210. Additional information regarding your ERISA rights may be found in your Summary of Benefits booklet under "Statement of ERISA Rights". The DOL website is at: www.dolgov.

Adoption Resolution

RESOLVED, that effective January 1, 2023, the Board of Trustees of the **San Mateo Electrical Workers Health Care Plan (**"PLAN") hereby adopts this Restated Summary Plan Description and Plan Document.

The benefits provided by the Plan can be paid only to the extent that the plan has available resources for such payments. No contributing employer has any liability, directly or indirectly to provide the benefits established hereunder, beyond the obligation of the contributing employer to make contributions required in the applicable collective bargaining agreement(s). Likewise, there shall be no liability imposed upon the Board of Trustees, individually or collectively, or upon the Union, Signatory association or any other person or entity of any kind to provide the benefits established hereunder if the Plan does not have sufficient assets to make benefits payments.

APPROVED: April 6, 2023

Scott Wein, Co-Chair

Date:_____

William H. Kuhr, Chair

Date: April 6, 2023