SOUTHERN CALIFORNIA DRUG BENEFIT FUND

Summary Plan Description & Plan Document for the Gold and Platinum Plans

Effective January 1, 2025

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INTRODUCTION

The Board of Trustees is pleased to provide you with the Gold and Platinum Plans of the Southern California Drug Benefit Fund (the "Fund"). The Gold and Platinum Plans provide comprehensive health benefits, including medical, hospital, prescription drug, mental health and substance use disorder, preventive care, dental, and vision benefits, as well as death benefits. The Platinum Plan also provides Supplemental Disability and Unemployment benefits.

This booklet is the Summary Plan Description ("SPD") for the Gold and Platinum Plans of the Fund. Together with the Restated Declaration of Trust Providing for the Establishment and Maintenance of the Southern California Drug Benefit Fund (the "Trust Agreement"), the collective bargaining agreements between the UFCW Union Locals and various Employers in the Retail Drug and Health Care Delivery Industries in Southern California (the "Collective Bargaining Agreements"), the Evidence of Coverage booklets issued by the Fund's HMO plans ("EOCs"), the contracts between the Fund and the HMOs, and other referenced documents, it is also the Plan Document for the Fund's Gold and Platinum Plans.

This Summary Plan Description & Plan Document describes the benefits, exclusions, and limitations of the Fund's Gold and Platinum Plans. It is effective January 1, 2025, and it replaces and supersedes all other plan documents, SPDs, and Summaries of Material Modifications ("SMMs") previously provided to Participants.

When benefits are provided by Health Maintenance Organizations ("HMOs"), the applicable EOC and the terms of any contracts between the Fund and the HMO will govern and supersede any conflicting terms contained in this booklet.

This Summary Plan Description & Plan Document may be amended from time to time. You will be sent an SMM explaining the changes that result from any such amendment. The benefits described in this booklet are not vested and may be modified, amended, or terminated at any time by the Board of Trustees in accordance with the Collective Bargaining Agreements and the Trust Agreement.

The Board of Trustees has the sole and exclusive authority to construe, apply, and interpret the Plan and all rules relating thereto, including the rules governing eligibility for and entitlement to benefits. Employees of the Fund Office and Union Locals have no authority to alter benefits or eligibility rules. Any interpretations or opinions given by Employees of the Fund Office or Union Locals are not binding upon the Board of Trustees.

Please read this booklet carefully, and keep the most up-to-date Plan Summary and Preventive Care Guidelines, as well as any SMMs, with this booklet for ease of reference.

Questions?

If you have any questions, please contact the Fund Office at the phone number and address located on the Quick Reference Chart starting on the next page.

QUICK REFERENCE CHART

When you need information, please check this booklet first. If you need further assistance, call the people listed in this Quick Reference Chart.

Note that the entities listed under "Whom to Contact" may change from time to time. To verify that a provider still delivers services to Plan Participants, call the Fund Office.

Information Needed	Whom to Contact
Contact the Fund Office for help with: • Eligibility • Enrollment • ID cards • Plan benefit questions • Claims and appeals for medical benefits under the Indemnity Medical Plan and vision benefits • Ancillary Fund benefits • Summary of Benefits and Coverage (SBC) and Plan Summaries • COBRA continuation coverage • Beneficiary designation for Death Benefits • Medicare Part D Notices of Creditable Coverage	**The Fund Office of the Southern California Drug Benefit Fund** **Mailing Address:** Southern California Drug Benefit Fund P.O. Box 27920 Los Angeles, CA 90027 **Street Address:** Southern California Drug Benefit Fund 2220 Hyperion Avenue Los Angeles, CA 90027 **Phone:** (323) 666-8910 (877) 999-8329 (toll free) **Fax:** (323) 913-0484 **Website:** www.ufcwdrugtrust.org
HIPAA Privacy Officer • HIPAA Notice of Privacy Practices • Complaints or concerns about privacy or your Protected Health Information (PHI)	**The Fund Office of the Southern California Drug Benefit Fund** **Mailing Address:** HIPAA Privacy Officer Southern California Drug Benefit Fund 2220 Hyperion Avenue Los Angeles, CA 90027 **Phone:** (323) 666-8910 Ext. 201 (877) 999-8329 Ext. 201 **Confidential Fax:** (323) 913-0484

Information Needed	Whom to Contact
Indemnity Medical Plan • PPO Provider Network for Medical and Mental Health/Substance Use Disorder services. *Always check with the Provider at the time of service to be sure they are still In-Network.* • Preauthorization of medical inpatient admissions, certain outpatient procedures, and other medical services. • Preauthorization of Mental Health/Substance Use Disorder Hospital admissions, intensive outpatient services, ECT, psychological testing, and neuropsychological testing. • Utilization Management (UM) for Medical and Mental Health/Substance Use Disorder services. • Appeals of Utilization Management decisions, including requests for Preauthorization. • Claims and appeals for Mental Health/Substance Use Disorder services. • Employee Assistance Program (EAP) through Anthem	**Anthem Blue Cross of California** **<u>To Find a PPO Provider</u>:** **In California:** Use the Anthem Blue Cross Prudent Buyer Network. **Website:** For the online Provider Directory, visit the Fund's website at https://ufcwdrugtrust.org/links/. **Phone:** You can also call Anthem at (800) 331-1476 or the Fund Office at (323) 666-8910 Ext. 503 or (877) 999-8329 Ext. 503. **Outside of California:** Use the BlueCard Network. **Website:** For the online provider directory, visit www.bcbs.com/find-a-doctor. **Phone:** You can also call BlueCard at (800) 810-2583 (800-810-BLUE). **<u>For Preauthorization</u>:** **In California:** Call Anthem at (800) 274-7767. **Outside of California:** Call BlueCard at (800) 810-2583 (800-810-BLUE). If you use a PPO Hospital, your Hospital or Physician will automatically request the Preauthorization for you, and Anthem or BlueCard will issue you a letter with their approval or denial. ***If you use a Non-PPO Provider, your Provider MUST call Anthem or BlueCard for Preauthorization.*** **CAUTION:** Except in case of emergency, use of a **Non-PPO** Hospital, facility, or Provider could result in you having to pay a substantial balance of the Provider's billing, including charges above the Plan's Allowed Amount (known as Balance Billing). **<u>For the Anthem EAP</u>:** **Phone:** (800) 999-7222 **Website:** You can also go to anthem.com/CA/EAP (and use code "So CA Drug" to log in).
Prescription Drug Program • Provides Prescription Drug coverage for Participants covered under the Indemnity Medical Plans, the Kaiser HMO, and the UHC HMO. • ID Cards for Prescription Drugs • Retail Participating Pharmacies • Prescription Drug information • Formulary Generic and Brand Name Drugs	**Optum Rx** **Phone:** (800) 788-7871 *Optum Rx call center representatives are available 24 hours a day, 7 days a week, to answer questions about the Prescription Drug Program.* **Website:** www.optumrx.com *Have your medical plan ID card handy - you'll need your member ID number from the card to use the site.*

Information Needed	Whom to Contact
Kaiser Permanente HMO Medical Plan (HMO Option) • Medical appointments • Kaiser customer service • Claims and appeals for Medical and Mental Health/Substance Use Disorder services • HMO benefit information • Preventive Care • To choose or change your Primary Care Physician	**Kaiser Permanente** **Phone:** (800) 464-4000 **Website:** www.kp.org
UHC HMO Medical Plan (HMO Option) • Medical appointments • UHC customer service • Prescription Drugs are provided through Optum Rx • Claims and appeals for Medical and Mental Health/Substance Use Disorder services • HMO benefit information • Preventive Care • To choose or change your Primary Care Physician	**UnitedHealthcare (UHC)** **Phone:** (800) 624-8822 **Website:** www.MyUHC.com
Indemnity Dental Plan • Dental Network Provider Directory • Dental claims and appeals	**Delta Dental** **Mailing Address:** P.O. Box 997330 Sacramento, CA 95899 **Phone:** (800) 765-6003 **Website:** www.deltadentalins.com Electronic claims payor ID: 77777
United Concordia Dental HMO Plan • Dental Network Provider Directory • Dental Claims and Appeals	**United Concordia** **Mailing Address:** P.O. Box 69420 Harrisburg, PA 17106-9420 **Phone:** (800) 937-6432 **Website:** www.unitedconcordia.com

I
ELIGIBILITY RULES

In this Chapter, the terms "you" and "your" refer to the Employee. The term "Spouse" refers to the Spouse or Domestic Partner of the Employee, unless specified otherwise.

Important Information about Eligibility and Coverage

To get Fund coverage, you must first earn initial eligibility by working **Qualifying Hours**. The earliest date you are eligible to participate in the Fund is called your **Initial Eligibility Date**. Your Initial Eligibility Date is the first day of the second month after you work Qualifying Hours.

Being eligible does not mean that your Fund coverage will automatically begin on your Initial Eligibility Date. Your coverage generally will not begin until the first of the month in which (i) you have enrolled for coverage and (ii) the Fund Office has received your first employee premium payment (whether paid by you directly or through payroll deduction).

If you want your coverage to begin on your Initial Eligibility Date, you must either: (i) enroll and pay your first monthly employee premium to the Fund Office before your Initial Eligibility Date; or (ii) call the Fund Office to arrange for a retroactive effective date and pay the necessary employee premiums.

You must submit your completed Enrollment Form to the Fund Office within 120 days after your Initial Eligibility Date or you will not be able to enroll yourself or your Dependents until the next Open Enrollment period, unless you or your Dependent has a Special Enrollment right.

For information about the Fund's enrollment rules, including Open Enrollment and Special Enrollment, see the next Chapter entitled "Enrollment."

Not all Fund benefits may be available on your Initial Eligibility Date. Even though you become eligible for Employee-only medical coverage on your Initial Eligibility Date, there is an additional waiting period for prescription drug and dental coverage, as well as for your Dependents to become eligible for coverage from the Fund. If you are a Pharmacist, however, there is an additional waiting period for dental coverage only.

After your Initial Eligibility Date, you must continue to work Qualifying Hours each Work Month and pay your monthly employee premium to maintain coverage for yourself and to earn or maintain coverage for your Dependents.

1. Initial Eligibility (When You Become Eligible for Coverage)

Important Terms

- **Initial Eligibility Date** – This is the first day you are eligible to participate in the Fund. It is the first day of the second calendar month after you have worked Qualifying Hours for two consecutive Work Months.
- **Qualifying Hours** – An average of 23 or more hours worked in Covered Employment for each whole week in your Employer's Work Month.
- **Work Month** – The Employer's monthly reporting period to the Fund (sometimes known as the monthly "payroll period"). Each Employer determines its own Work Month. Your Employer's Work Month could be a calendar month or a 4-, 5-, or 6- week period. For Employers with Works Months that are not based on calendar months, the Work Month corresponds to the calendar month in which the Work Month ends. For example, an Employer's 4-week Work Month that ends on January 21 is the January Work Month. To obtain the specific dates of each Work Month for your Employer, contact the Eligibility Department of the Fund Office.

Special Initial Eligibility Rules

Special Initial Eligibility Rules apply to Employees who were connected to an Employer or were eligible for coverage under another UFCW trust fund in California prior to beginning Covered Employment. *If you think one of these special rules might apply to you, see Subsection B ("Special Initial Eligibility Rules") of this Section, below, and the Appendix at the back of this booklet.*

A. General Initial Eligibility Rules for New Employees

(1) Employee-Only Medical Coverage – You become eligible for Employee-only medical coverage on your Initial Eligibility Date. Your Initial Eligibility Date is the first day of the second calendar month after you have worked Qualifying Hours for two consecutive Work Months.

For example: *You are hired and start working in May. You work Qualifying Hours in the May and June Work Months. Your Initial Eligibility Date will be August 1, as long as you are still employed in Covered Employment on August 1.*

(2) Prescription Drug and Dependent Coverage – You will become eligible for prescription drug coverage, and your Dependents will become eligible for medical and prescription drug coverage, on the earlier of:

(a) The first month after you have been eligible for coverage for six months (generally the seventh month after your Initial Eligibility Date), if you have continued to work Qualifying Hours; or

(b) The first day of the second month after you work 1,200 straight-time hours in Covered Employment.

(3) Dental Coverage – You and your enrolled Dependents will become eligible for dental coverage on the first month after you have been eligible for coverage for six months (generally the seventh month after your Initial Eligibility Date), if you have continued to work Qualifying Hours.

(4) If You Are a Pharmacist – If you are a Pharmacist, different rules apply to you as follows:

(a) You and your enrolled Dependents will become eligible for all benefits, except dental benefits, on your Initial Eligibility Date. Your Initial Eligibility Date is the first day of the second calendar month after you have worked Qualifying Hours for two consecutive Work Months.

(b) You and your enrolled Dependents will become eligible for dental benefits on the first month after you have been eligible for coverage for six months (generally the seventh month after your Initial Eligibility Date), if you have continued to work Qualifying Hours.

After your Initial Eligibility Date, you must continue to work Qualifying Hours each Work Month to continue your eligibility. *See Section 3 ("Continuing Eligibility") of this Chapter, below, for more information about continued eligibility.*

B. Special Initial Eligibility Rules

The Fund has special rules for initial eligibility that may apply to you if:

- You are transferred by your Employer into a position that is covered by this Fund; or
- You are employed in a new store or a newly organized store of an existing Employer; or
- You work for a newly organized Employer; or
- You were working under another UFCW Fund in California immediately before beginning Covered Employment (Reciprocity).

If you think one of these Special Initial Eligibility Rules apply to you, **you must notify the Fund Office within 60 days after the date you begin work in Covered Employment**. Otherwise, you will earn eligibility under the "General Initial Eligibility Rules for New Employees" (described in Subsection A of this Section, above). *See the Appendix at the back of this booklet for more information about these Special Initial Eligibility Rules.*

Remember: Being "eligible" does not mean you have coverage from the Fund. You must be enrolled and have paid your monthly employee premium before you can begin Fund coverage. *For information about Enrollment, see the next Chapter entitled "Enrollment."*

2. When Coverage Starts (Effective Date of Health Coverage)

- In addition to earning initial eligibility, you must enroll for coverage and pay your employee premium for your first month of coverage before your coverage will begin.
- You have a choice as to when your coverage begins. If you timely enroll, you can generally choose to have your coverage retroactive to your Initial Eligibility Date. However, you must call the Fund Office to arrange for a retroactive effective date.
- Most Participants are not eligible for all benefits on their Initial Eligibility Date. You may have an additional waiting period for prescription drug and dental coverage and for your Dependents to become eligible for coverage.

For information about enrollment and required employee premiums, see the next Chapter entitled "Enrollment."

A. Enrollment before Initial Eligibility Date

If you submit your Enrollment Form and pay your first monthly employee premium before your Initial Eligibility Date, your coverage will be effective on your Initial Eligibility Date.

B. Enrollment after Initial Eligibility Date

If you complete your enrollment within 120 days after your Initial Eligibility Date, your coverage will generally begin on the first day of the month in which the Fund Office receives your first employee premium payment (either from you directly or by payroll deduction).

However, you can request that your effective date of coverage be retroactive to an earlier date (but no earlier than your Initial Eligibility Date). To do so, you must contact the Fund Office to request an earlier effective date (and for help in determining the amount of employee premiums that you must submit to get that earlier effective date).

For example: *You are hired in August 2023 and work Qualifying Hours in the August and September 2023 Work Months and for each Work Month thereafter. Your Initial Eligibility Date is November 1, 2023. You turn in your completed Enrollment Form to the Fund Office on January 12, 2024, along with a payment for one month of employee premiums. Your coverage will begin on January 1, 2024. If you want your coverage to begin on November 1, 2023, you will need to call the Fund Office to request an earlier effective date, and you will need to pay monthly employee premiums retroactive to November 1, 2023.*

Remember: You must submit your completed Enrollment Form to the Fund Office within 120 days after your Initial Eligibility Date. If you do not do so, you will not be able to enroll yourself or your Dependents until the next Open Enrollment period, unless you or your Dependent has a Special Enrollment right. *For information about the Fund's enrollment rules, including Open Enrollment and Special Enrollment, see the next Chapter entitled "Enrollment."*

3. Continuing Eligibility

A. Working Qualifying Hours

Once you earn initial eligibility, you must work Qualifying Hours each Work Month, or an average of Qualifying Hours over three consecutive Work Months ("Rolling Three Months"), to continue your eligibility for coverage.

You earn coverage for an Eligibility Month (also called a coverage month) if you work Qualifying Hours in the Work Month (or if you average Qualifying Hours over the Rolling Three-Month period) that ends two months before that Eligibility Month, as long as you are still employed by your Employer.

The two months between a Work Month (or Rolling Three-Month period) and the corresponding Eligibility Month are known as Skip Months. Continuing eligibility for Fund coverage is determined on the basis of a "Two-Skip-Month" rule, as shown in the chart below:

QUALIFYING HOURS IN WORK MONTH…	OR	AVERAGING QUALIFYING HOURS IN ROLLING THREE MONTHS…		…EARNS COVERAGE IN ELIGIBILITY MONTH
January		November, December, January	⇨	April
February		December, January, February	⇨	May
March		January, February, March	⇨	June
April		February, March, April	⇨	July
May		March, April, May	⇨	August
June		April, May, June	⇨	September
July		May, June, July	⇨	October
August		June, July, August	⇨	November
September		July, August, September	⇨	December
October		August, September, October	⇨	January
November		September, October, November	⇨	February
December		October, November, December	⇨	March

Example 1: *You work Qualifying Hours in the March Work Month. You are eligible for coverage in June (work in March, skip April and May, eligible in June), as long as you are still employed by your Employer.*

Example 2: *You do not work Qualifying Hours in the May Work Month. However, your combined hours worked over the Rolling Three-Month period from the March through May Work Months average to meet Qualifying Hours. You are eligible for coverage in August, as long as you are still employed by your Employer.*

B. Anniversary Vacation

You may be able to use a payout of vacation time to satisfy the Qualifying Hours requirement.

If you receive a payout of vacation time from your Employer for a period of time when you were not on vacation (typically in your anniversary month), you may request that the Fund Office credit those vacation hours to the Work Month in which you actually took vacation. (When you receive vacation pay from your Employer during a period when you actually take a vacation, your vacation hours are credited to the Work Month in which you received vacation pay).

4. Dependent Coverage

Although you become eligible for coverage on your Initial Eligibility Date, your Dependents may have an extended waiting period before they become eligible for coverage. The date your Dependents become eligible for coverage depends on how you become eligible for coverage (i.e., whether you become eligible under the "General Initial Eligibility Rules for New Employees," described in Section 1.A of this Chapter, or under one of the "Special Initial Eligibility Rules," described in Section 1.B of this Chapter and in the Appendix at the back of this booklet). If you are not sure when your Dependents become eligible for coverage, please contact the Fund Office.

For your Dependents to become covered under the Fund, you must enroll them for coverage and pay the applicable monthly employee premium. A Dependent may not be enrolled for coverage unless you (the Employee) are also enrolled. *See the next Chapter entitled "Enrollment" for information on how to enroll for coverage*.

If you enroll your Dependents when you first enroll for coverage, your Dependents will generally become covered under the Fund on the date they become eligible for coverage (or, if later, on the date you first become covered under the Fund). *See Section 1.A ("General Initial Eligibility Rules for New Employees") of this Chapter, above, for information about when Dependents gain eligibility for coverage*.

Dependents acquired later (such as by marriage, birth, adoption, or placement for adoption, or as required by a Qualified Medical Child Support Order) may be enrolled under a Special Enrollment right or during an Open Enrollment period. *See the next Chapter entitled "Enrollment" for information about Special Enrollment and Open Enrollment*.

A. Qualified Dependents

Only individuals who qualify as your Dependents can be enrolled for coverage under the Fund. Your Dependents who can be enrolled for coverage include:

(1) Your **lawful Spouse** or **Domestic Partner**.

Working Spouse Rule

If your enrolled Spouse/Domestic Partner works in a position for which employer-provided health coverage is available, your Spouse/Domestic Partner must enroll in his or her employer's coverage. Otherwise, this Fund will generally pay only 40% of its regular benefits. *For more information about the Working Spouse Rule, see Subsection E ("The Working Spouse Rule") of this Section 4, below*.

(2) Your **natural children** who are under the age of 26.

(3) Your **stepchildren** who are under the age of 26.

(4) Your **Foster Children** who satisfy the requirements described in Subsection B ("Foster Children") of this Section 4, below. No more than two Foster Children may be enrolled as your Dependents.

(5) Your **adopted children and those placed with you for adoption** who are under the age of 26 (the placement date is the date you become legally obligated to provide full or partial support for the placed child).

(6) Your **Domestic Partner's children** who are under the age of 26.

(7) A child under the age of 26 for whom you are required to provide coverage in accordance with a **Qualified Medical Child Support Order**. *For more information, see Subsection D ("Coverage for Children Under a Qualified Medical Child Support Order ("QMCSO")") of this Section 4, below*.

(8) Your **Disabled Adult Children over the age of 26** who satisfy the requirements described in Subsection C ("Disabled Over-Age Children") of this Section 4, below.

You must submit documentation to substantiate each Dependent's eligibility to the Fund Office. This may include a birth certificate, marriage certificate or declaration of domestic partnership, proof of the Dependent's age, and/or the Dependent's Social Security Number. Failure to timely provide the required documentation will lead to a determination that your Dependent is not eligible for coverage. You will not be able to enroll the Dependent until the next annual Open Enrollment, unless you or your Dependent has a Special Enrollment right.

Domestic Partners and their children may not qualify as dependents under Federal tax rules. The value of the coverage provided to your Domestic Partner and/or the child(ren) of your Domestic Partner, less any employee premium paid for such coverage, may be taxable as "imputed income" to the Employee. If your Domestic Partner (or your Domestic Partner's child(ren)) do not qualify as your dependent(s) under Federal tax rules, the Fund is required to collect tax withholding from you and pay it to the IRS on your behalf.

B. Foster Children

A child who is not your or your Spouse's natural or adopted child and who qualifies as a Foster Child may be enrolled as your Dependent. You cannot enroll more than two Foster Children as your Dependents.

To qualify as your Foster Child, each of the following criteria must be satisfied:

(1) A court order must establish that you or your Spouse are the Foster Child's legal guardian.

(2) The Foster Child must be unmarried and under the age of 19 (or under the age of 24, if the child resided with you for at least five years before reaching age 19 and qualifies as a Full-Time Student under the Fund's rules), must be entirely supported by and financially dependent upon you, and must reside in your home. (If you or your Spouse receive any income on behalf of the Foster Child, other than orphan Social Security benefits and/or periodic disbursements from life insurance or other estate funds, the Foster Child will not be eligible for coverage).

(3) You or your Spouse must claim the Foster Child as a dependent on your federal income tax return. You are required to provide the Fund Office with annual proof that you claim the Foster Child as

your dependent on your federal income tax return, except for the first year that the child qualifies as your Foster Child.

Disabled Student Coverage for Foster Children Age 19 or Older Who Are Covered by the Fund as Full-Time Students. The Fund provides an extension of coverage for up to one year (called "Disabled Student Coverage") to Foster Children who lose their Full-Time Student status as the result of serious illness or injury. To qualify for Disabled Student Coverage, your Foster Child must satisfy each of the following requirements:

(i) The child must take a Medically Necessary leave of absence from (or experience a change in enrollment at) a postsecondary institution that begins while the child is suffering from a serious illness or injury.

(ii) The leave of absence (or change in enrollment) must cause your child to lose "Full-Time Student" status for purposes of Fund eligibility.

(iii) The child must have had Fund coverage immediately before the first day of the child's leave of absence (or change in enrollment).

Disabled Student Coverage begins on the first day of the Medically Necessary leave of absence (or change in enrollment) and ends on the date that is the earliest of: (1) one year later; (2) the last day of the month in which the child no longer satisfies the above requirements to qualify for Disabled Student Coverage; or (3) the date on which coverage would otherwise terminate under the Fund (e.g., when the child attains age 24).

To apply for Disabled Student Coverage, obtain a copy of the Student Certification form from the Fund Office, your Union Local, or the Fund's website. Complete Part A of the form and have your child's treating physician complete Part D. Return the Student Certification form to the Fund Office within 60 days. You are strongly encouraged to complete and submit the Student Certification form (Parts A and D) to the Fund Office as soon as possible to avoid confusion or temporary loss of coverage.

C. Disabled Over-Age Children

If your child becomes disabled before his or her 26th birthday (or age 19 or 24, as applicable, for Foster Children), coverage may be continued during the period of disability if all of the following conditions are met:

(1) Your child is incapable of self-sustaining employment due to a physical or mental disability (as verified by a doctor's statement and subject to the Fund's review) and is chiefly dependent on you for support and maintenance.

(2) The child was covered under the Fund as your Dependent before reaching the applicable age limit (age 26, or for Foster Children, age 19 or 24, as applicable).

(3) You submit an application to the Fund Office for the continuation of your Dependent's coverage within 60 days after the child attains the applicable age limit. If you are enrolled in one of the Fund's HMO Plans, you may be required to respond to the HMO's notice within 60 days after receipt of notification from the HMO.

(4) You submit proof of your child's continuing disability before October 1 of each year, which must include a doctor's statement concerning your child's continuing disability. (If you are enrolled in one of the Fund's HMO Plans, you may be required to submit such proof to the HMO annually, beginning two years after the child reaches the age limit.)

HMO Enrollees: If you are enrolled in one of the Fund's HMO Plans and your child is disabled, you may have additional rights through your HMO Plan that are not described here.

D. Coverage for Children under a Qualified Medical Child Support Order ("QMCSO")

The Fund will provide benefits in accordance with a Qualified Medical Child Support Order ("QMCSO") or a National Medical Support Notice. Under federal law, a QMCSO is a judgment, decree, or order (issued by a court or resulting from a state's administrative proceeding) that creates or recognizes the rights of a child, also called the "alternate recipient," to receive benefits under a group health plan, typically the non-custodial parent's plan. The QMCSO may require the Fund to recognize the child as a Dependent, even though the child may not meet the Fund's definition of Dependent. A QMCSO may result from a divorce and typically:

- Designates one parent to pay for a child's health plan coverage and/or provide coverage through the parent's health plan coverage;
- Indicates the name and last known address of the parent required to pay for the coverage and the name and mailing address of each child covered by the QMCSO;
- Contains a reasonable description of the type of coverage to be provided under the designated parent's health care plan or the manner in which such type of coverage is to be determined;
- States the period for which the QMCSO applies; and
- Identifies each health care plan to which the QMCSO applies.

An order is not a QMCSO if it requires the Fund to provide any type or form of benefit or any benefit option that the Fund does not otherwise provide, except as required by a state's Medicaid-related child support laws. For a state administrative agency order to be a QMCSO, state statutory law must provide that such an order will have the force and effect of law, and the order must be issued through an administrative process established by state law.

If a court or state administrative agency has issued an order with respect to health care coverage for any child of the Employee, the Plan Administrator or its designee will determine if that order is a QMCSO as defined by federal law. That determination will be binding on the Employee, the other parent, the child, and any other party acting on behalf of the child. The Plan Administrator or its designee will notify the parents if an order is determined to be a QMCSO, and if the Employee is covered by the Fund, advise them of the procedures to be followed to provide coverage of the Dependent Child.

If the Plan Administrator or its designee determines that an order is a valid QMCSO, and the child is not already enrolled for coverage, the Fund Office will process a mandatory enrollment of the child as of the earliest required date (after determining the order is valid) that the child is eligible for coverage, without regard to typical enrollment restrictions. If you (i.e., the Employee) are not already enrolled for coverage, the Fund Office will enroll both you and the child for coverage, as the child cannot have coverage from the Fund unless you are also covered. The QMCSO may require the Fund to accept contributions for the

child's coverage from a parent who is not a Fund Participant. The Fund Office will accept a request for enrollment of the child specified by the QMCSO from either the Employee or the custodial parent.

Coverage will be subject to all terms and provisions of the Fund, including any requirements for authorization of services, as permitted by applicable law.

No coverage will be provided for any child under a QMCSO unless the applicable employee premiums for that child's coverage are paid and all of the Fund's requirements for enrollment and coverage of that child have been satisfied. Contributions required for coverage under a QMCSO are the total employee premiums required for coverage of the Employee plus eligible Children. If you haven't paid employee premiums or completed an Authorization for Payroll Deduction form, your Employer will begin to withhold the appropriate premiums to provide coverage to you and a child you are required to cover under a QMCSO.

Generally, Fund coverage terminates for the child when the period the QMCSO requires coverage ends or for the same reasons coverage otherwise terminates under the Fund for other children. This includes termination of coverage for failure to pay any required employee premiums. When coverage terminates, the child may be eligible for COBRA Continuation Coverage. *For more information about COBRA, see the Chapter entitled "COBRA & USERRA: Temporary Continuation of Health Coverage."*

For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Fund Office.

E. The Working Spouse Rule

For purposes of this rule, the term "Spouse" refers to both Spouses and Domestic Partners.

If your Spouse is employed, he or she must enroll in health coverage offered by his or her employer – even if your Spouse must pay any part of the cost of the coverage.

If your Spouse is eligible for his or her employer's medical, dental, or vision care plans but does not enroll, <u>this Fund will cover only 40% of its normal benefits</u>.

- This means that the Fund will **reduce the benefits otherwise payable by 60%**.
- This **60% reduction** is a **financial penalty** for failure to comply with the Working Spouse Rule, and **your additional Cost Sharing does not apply towards the annual medical Out-of- Pocket Maximum**.

This reduction applies to all services except Emergency Services.

Under this rule, your Spouse must choose a coverage option offered by his or her employer that is comparable to the coverage offered by the Fund or, if none of the options is comparable to your coverage under the Fund, the best health coverage available.

If your Spouse chooses an HMO through his or her employer, a plan that is "comparable to" the Fund's coverage will generally be the one with the most similar copayments (and deductible, if applicable) as your Plan under the Fund. If your Spouse chooses a PPO or indemnity plan from his or her employer, a plan that is "comparable to" Fund coverage will generally be the one with the same or most similar

coinsurance and/or deductible. Your Spouse's plan will provide primary coverage for your Spouse, and your Spouse should submit claims to that plan first. This Fund will provide secondary coverage.

Your Spouse is required to enroll for coverage only for himself or herself through his or her employer. Your Spouse is not required to cover you or your children. If your Spouse is not working now, or if your Spouse's employer does not currently offer any benefits, this Fund will pay its normal benefits. However, the 60% reduction in benefits will apply immediately if and when your Spouse becomes eligible for any of the benefits specified above through an employer.

To avoid loss of benefits and higher out of pocket costs, be sure that your Spouse enrolls for any employer-sponsored benefits as soon as possible. If your Spouse is unable to enroll at this time, the benefit reduction will apply beginning with the earliest date that your Spouse could have enrolled.

If your Spouse stops working or loses his or her other coverage (for example, because of a change from full-time to part-time employment), contact the Fund Office immediately.

5. When Coverage Ends

This Section describes how you and your Dependents can lose Fund coverage and when coverage will end.

A. Termination of Employee Coverage

Your coverage will end upon the earliest occurrence of any of the following:

(1) Your employment ends. Your coverage will terminate on the last day of the month in which your employment ends.

Exceptions:

(a) If your employment ends while you are on Disability Extended Coverage, Workers' Compensation Extended Coverage, or an extension of eligibility for FMLA and/or CFRA leave, your coverage will terminate when your Extended Coverage or eligibility extension ends, in accordance with Subsection A ("Extended Coverage while You Are Disabled, Unemployed, or on Workers' Compensation") of Section 6 of this Chapter.

(b) If you are in the Gold Plan, and you retire and commence pension benefits from the Southern California United Food and Commercial Workers Unions and Drug Employers Pension Fund or the Southern California General Sales Employers and United Food and Commercial Workers Unions Pension Fund, your coverage will not terminate due to your employment ending. Instead, your coverage will terminate when you are no longer eligible for coverage due to insufficient hours (i.e., you have a run-out of coverage).

(2) You fail to work enough hours to continue your eligibility. Your coverage will terminate on the last day of the final month in which you were eligible for coverage as a result of working Qualifying Hours.

For example: *If you last worked Qualifying Hours in the June Work Month (and did not work enough hours in the May, June, and July Rolling Three-Month period to maintain eligibility for October), your coverage will terminate on September 30.*

(3) You fail to pay your employee premiums. Your coverage will end on the last day of the month for which employee premiums were paid.

(4) You elect to terminate your coverage. Your coverage will end on the last day of the month in which you notify the Fund Office, in writing, that you wish to terminate your coverage.

(5) You die. Your coverage will end on the last day of the month in which you die.

(6) Your Employer is no longer required to contribute to the Fund. Your coverage will end on the last day of the month in which your Employer ceases to have an obligation to contribute to the Fund.

(7) Your Employer is delinquent in paying contributions to the Fund for three or more months. You will be provided advance notice of the date your coverage will end if your Employer fails to cure its delinquency within 30 days following notice of the three-month delinquency.

(8) The Fund terminates. Your coverage will end on the date the Fund terminates.

B. Termination of Dependent Coverage

Dependent coverage will end upon the earliest occurrence of any of the following:

(1) When your coverage ends. Your Dependents' coverage will terminate on the same date your coverage ends.

(2) When your covered Spouse no longer satisfies the Fund's definition of Dependent (because, for example, you divorce). Your Spouse's coverage will end on the last day of the month in which your Spouse ceases to meet the Fund's definition of Dependent.

(3) When your covered child(ren) no longer satisfies the Fund's definition of Dependent. Your child's coverage will end on the last day of the month in which your child ceases to meet the Fund's definition of Dependent. For example, your child will no longer meet the Fund's definition of Dependent when:

(a) Your child reaches age 26.

(b) Your Foster Child reaches age 19 (or, if covered as a Full-Time Student, age 24).

(c) You divorce and your former Spouse and stepchild(ren) no longer qualify as your Dependents.

(d) Your Disabled Adult Child (above age 26) recovers from his/her disabling condition.

(e) You fail to provide proof that your Disabled Adult Child (above age 26) continues to be disabled.

You Must Notify the Fund if Your Dependent Becomes Ineligible for Coverage

You (or any of your Dependents) must notify the Fund Office if any of your Dependents lose Dependent status or otherwise become ineligible for Fund coverage **as soon as possible but no later than 60 days after the date**:

- **Your marriage is dissolved (you get divorced) —** Provide the Fund with the date of your dissolution of marriage and a copy of the Dissolution of Marriage.
- **Your Domestic Partnership terminates** — Provide the Fund with the date of the termination and a copy of the Decree of Dissolution of Domestic Partnership or a completed Notice of Termination of Domestic Partnership.
- **Your child no longer qualifies as a Dependent** because of age, loss of status as your Foster Child or stepchild, or loss of Full-Time Student status (applicable to Foster Children), or because your child no longer qualifies for coverage as a Disabled Over-Age Child — Provide the date your child ceased to be eligible for coverage.
- **Your covered Dependent dies —** Contact your Union Local or the Fund Office for assistance.

You can notify the Fund Office of these events by sending a letter to the Fund Office or by disenrolling your Dependent(s). To disenroll your Dependent(s), complete an Enrollment Form, making sure to check the appropriate boxes to disenroll your Dependent(s), and then return the form to your Union Local or to the Fund Office. Enrollment Forms are available on the Fund's website or by calling the Fund Office.

If you fail to timely notify the Fund Office that your Dependent has become ineligible for coverage, you will be responsible for reimbursing the Fund for any benefits paid in error, including any premiums the Fund paid for HMO coverage.

For example: *If you fail to notify the Fund of a divorce, and the Fund continues to provide benefits and/or pay premiums on behalf of your former Spouse, you will be required to reimburse the Fund for the benefits and/or premiums paid in extending coverage to your former Spouse after the divorce (when he or she ceased to qualify as your Dependent).*

If you timely notify the Fund Office, your Dependent may have the opportunity to elect COBRA continuation coverage. *For more information about COBRA, please see the Chapter entitled "COBRA & USERRA: Temporary Continuation of Health Coverage."*

C. Rescissions of Coverage

In accordance with federal law, the Fund will not retroactively cancel or terminate coverage (a Rescission of Coverage) except in the circumstances permitted by law, such as: (i) when contributions or self-payments are not timely paid; or (ii) upon 30 days' advance written notice, in cases when an individual performs an act, practice, or omission that constitutes fraud or makes an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

Retroactive termination of an ex-spouse's coverage due to the failure to timely notify the Fund Office of a divorce or dissolution of marriage is not a "Rescission of Coverage."

The following examples constitute a material misrepresentation for which the Fund may rescind (retroactively cancel) coverage: (i) knowingly enrolling someone as a Dependent who does not qualify as a Dependent; or (ii) knowingly submitting a false claim or appeal for benefits.

6. Extensions of Eligibility

A. Extended Coverage while You Are Disabled, Unemployed, or on Workers' Compensation

If you are unable to work because of a disability or because you are unemployed, you may qualify for Extended Coverage from the Fund. If you qualify for Extended Coverage, your eligibility (and the eligibility of your enrolled Dependents) may be continued for up to 6 months (12 months for a work-related disability for which you receive Workers' Compensation benefits), as described in more detail below.

You are required to pay your employee premiums for each month of Extended Coverage, and you must provide the Fund Office with the documentation necessary to establish your entitlement to Extended Coverage.

If you will lose eligibility because you did not work Qualifying Hours, the Fund Office will mail you information about Extended Coverage and the Self-Payment option. You may also request an application for Extended Coverage by calling the Eligibility Department at the Fund Office.

You should submit your application for Extended Coverage to the Fund Office as soon as possible to avoid any lapse in coverage.

In addition to the application for Extended Coverage, you must submit the following documentation, as applicable, to the Fund Office:

For Disability Extended Coverage:	**For Workers' Compensation Extended Coverage:**	**For Unemployment Extended Coverage:**
⇒ Notice of Computation from the Employment Development Department (EDD) ⇒ Record of Disability Benefits Paid (payment stubs or other proof of disability payments) ⇒ Any notices concerning changes to your benefits	⇒ Notice of Award or Approval Letter from Workers' Comp. Carrier ⇒ Copies of check stubs from Workers' Comp. carrier ⇒ Any other notices concerning changes to your benefits	⇒ Notice of Unemployment Insurance Award from the Employment Development Department (EDD) ⇒ Check stubs or photocopies of your State Unemployment Checks

After you submit your application and the required documentation, you will need to continue to submit paystubs or copies of checks showing benefit payments to you from the State or Workers' Compensation carrier.

(1) Disability or Unemployment – If you are disabled and receiving State disability benefits (or disability benefits from a State-approved voluntary plan), or if you are unemployed and receiving State unemployment benefits, you will be credited with Qualifying Hours for up to 6 consecutive Work Months beginning with the first Work Month for which Qualifying Hours are needed to avoid a loss of coverage, if you satisfy each of the following requirements:

(a) You had Fund coverage as follows:

(i) *For Disability Extended Coverage*: You had Fund coverage in the month your claim for State disability benefits (or your claim for disability benefits from a State-approved voluntary plan) was established.

(ii) *For Unemployment Extended Coverage*: You had Fund coverage in the month your claim for State unemployment benefits was established (or in the month prior to the month your claim was established).

(b) You must receive State disability benefits (or disability benefits from a State-approved voluntary plan) or State unemployment benefits for the same period that Qualifying Hours are to be granted.

(c) You must have worked in Covered Employment for one of the following:

(i) 400 hours in the 6 Work Months immediately prior to the Work Month in which the unemployment or disability claim is established by the State; or

(ii) 700 hours in the 12 Work Months immediately prior to the Work Month in which the claim is established by the State; or

(iii) 1,000 hours in the 18 Work Months immediately prior to the Work Month in which the claim is established by the State.

* *A period of qualifying military service will be "lifted out" of the 6-, 12-, or 18-Work Month periods above. Qualifying Hours worked in Covered Employment before and after such Military Service will be used toward meeting any of the above hourly requirements.*

For Unemployment Extended Coverage: A period during which you were credited with Qualifying Hours for disability will count as time worked in satisfying any of the above hourly requirements.

(2) Workers' Compensation Disability – If you are receiving temporary Workers' Compensation benefits due to a work-related disability, you will be credited with Qualifying Hours for up to 12 consecutive months, beginning with the first Work Month for which Qualifying Hours are needed to avoid a loss of coverage, if you satisfy all of the following requirements:

(a) You must have sustained a disabling injury or illness as a result of working in Covered Employment.

(b) You had Fund coverage (i) in the month in which you sustained the Workers' Compensation injury or illness and (ii) in the month you received your first payment of Workers' Compensation benefits.

(c) You must receive temporary Workers' Compensation benefits (or temporary partial

Worker's Compensation benefits) from your Employer's Workers' Compensation carrier that are allocated to the same period for which Qualifying Hours are to be granted.

(3) Additional Rules and Limitations Applicable to Extended Coverage

(a) If you have exhausted your 6-month period of Disability Extended Coverage or 12-month period of Workers' Compensation Extended Coverage, you must return to Covered Employment and work Qualifying Hours for 2 consecutive Work Months before you can qualify for a new 6- or 12-month period of Extended Coverage for Disability, Workers' Compensation, or Unemployment.

(b) If you did not exhaust your 6-month period of Disability Extended Coverage before you returned to Covered Employment, and you suffer a second period of disability before working at least 2 consecutive Work Months of Qualifying Hours, you may qualify for additional months of Extended Coverage, as follows:

(i) You may qualify for the remainder of your 6-month period of Disability Extended Coverage if you continue to satisfy the requirements for Disability Extended Coverage in this Subsection A.

(ii) If you suffer a Workers' Compensation disability following your return to work, you may qualify for Workers' Compensation Extended Coverage for up to 12 consecutive months minus the number of months of Disability Extended Coverage that you previously received, as long as you satisfy the requirements for Workers' Compensation Extended Coverage in this Subsection A.

For example: *If you used 5 months of Disability Extended Coverage, then suffered a work-related injury 3 weeks after returning to Covered Employment, you could qualify for up to 7 months of Workers' Compensation Extended Coverage.*

(c) If you did not exhaust your 12-month period of Workers' Compensation Extended Coverage before you returned to Covered Employment, and you suffer a second period of disability before you worked at least 2 consecutive Work Months of Qualifying Hours, you may qualify for additional months of Extended Coverage, as follows:

⇒ You may qualify for the remainder of your 12-month period of Workers' Compensation Extended Coverage if you continue to satisfy the requirements for Workers' Compensation Extended Coverage in this Subsection A.

⇒ If you suffer a non-work-related disability following your return to Covered Employment, you may qualify for Disability Extended Coverage for the lesser of: (i) 12 months minus the number of months of Workers' Compensation Extended Coverage that you previously received; or (ii) 6 months, as long as you satisfy the requirements for Disability Extended Coverage in this Subsection A.

(d) If you previously had a claim for State unemployment benefits that was established within 18 months before the date your new claim for State unemployment benefits is established, you will not be eligible for additional months of Extended Coverage from the Fund, unless you worked at least 700 hours in Covered Employment within the 12 Work Months immediately preceding the date of your new claim for State unemployment benefits.

(e) Disability or Unemployment Extended Coverage will not be granted, except in extraordinary circumstances approved by the Trustees, unless your application for Extended Coverage is submitted to the Fund Office within one year after the date your State disability or State Unemployment claim (or claim with a State-approved voluntary disability plan) is established.

(f) Workers' Compensation Extended Coverage will not be granted unless your application for Extended Coverage is submitted to the Fund Office within one year after the date your Workers' Compensation claim is established or the date of the first payment by the Worker's Compensation Carrier, whichever is later.

(g) Notwithstanding the above, for Participants enrolled in an HMO plan, retroactive coverage will be provided only to the extent permitted by the HMO. For Participants enrolled in the Indemnity Medical Plan, retroactive coverage will be provided only to the extent permitted by Anthem Blue Cross.

(h) Workers' Compensation Extended Coverage will not be granted if you receive a lump sum payment from the Workers' Compensation carrier in settlement of a claim which lump sum is not attributed to a specific period of time during which temporary Workers' Compensation benefits are paid.

(i) Workers' Compensation Extended Coverage will not be granted if you are receiving permanent Workers' Compensation benefits.

B. Extending Coverage by Self-Payment

If you don't work enough hours to maintain your eligibility, you may continue coverage for yourself and your enrolled Dependents for a limited time by paying the self-payment premium set by the Fund. The self-payment option is not available after your employment is terminated, unless you return to Covered Employment within 30 days from the date you last worked in Covered Employment.

The amount of the self-payment premium is set from time to time by the Board of Trustees. Self-payment premiums may be less than COBRA premiums, particularly if you have hours reported during the corresponding Work Month, in which case the amount of the self-payment premium is reduced.

To continue your coverage without interruption, your self-payment premium must be paid by the due date shown on the self-payment notice that is mailed to you. You must also pay your employee premiums for each month that you self-pay for coverage.

The self-payment option is available under the following four circumstances:

(1) Insufficient Hours – If you remain in Covered Employment but have not worked sufficient hours to maintain your eligibility, the Fund will send you a self-payment billing statement. If you pay the self-payment premium by the due date shown on the statement, your coverage will continue for one month. You may continue your coverage through self-payment, without interruption, for a maximum of three consecutive months.

Example: *You are not eligible for coverage in July because you did not work Qualifying Hours in the April Work Month (and you did not average Qualifying Hours over the Rolling Three-Month period ending in the April Work Month). In early June, the Fund Office will send you a notice allowing you to self-pay for July coverage. If you pay the self-payment premium by the due date shown in the notice,*

coverage for you and your enrolled Dependents will be continued for the month of July. If you do not self-pay by the due date, your coverage will terminate on June 30. If, after you self-pay for July, you do not work sufficient hours again in the May Work Month, the Fund Office will send you another self-payment notice at the beginning of July, and you can again choose to self-pay for August coverage.

(2) Maternity Leave – You may self-pay for coverage while you are on maternity leave. However, the total number of months for which you are permitted to make self-payments, combined with any Extended Coverage due to disability, may not exceed six months. Please contact the Fund Office for more information or to obtain forms to self-pay for coverage during a maternity leave.

(3) Exhaustion of Extended Coverage Based on Disability or Workers' Compensation – If you are disabled, and you have exhausted your Extended Coverage based on disability or Workers' Compensation, you may self-pay for a maximum of three consecutive months, provided that you (i) continue to receive, during the corresponding Work Month, either State disability benefits (or disability benefits from a State-approved voluntary plan) or temporary Workers' Compensation benefits, and (ii) satisfy the other applicable requirements for Extended Coverage described in Subsection A ("Extended Coverage While You are Disabled, Unemployed, or on Workers' Compensation") of this Section 6, above.

(4) Employer Delinquency – If your coverage terminates because your Employer is delinquent in paying contributions to the Fund, you may continue your coverage by making self-payments for up to a maximum of six consecutive months. If your Employer subsequently pays the delinquent contributions and your eligibility is restored, the Fund Office will refund your self-payments to you.

C. Extensions Due to Hospitalization/Maternity

(1) Hospitalization (Employee Only) **–** If you (i.e., the Employee) are in the Indemnity Medical Plan and are hospitalized at the time your coverage terminates, the Fund will continue your coverage until you are released from the Hospital or until confinement in the Hospital is no longer Medically Necessary. This coverage extension is only available to covered Employees and not to Dependents.

(2) Maternity Benefit Extension (Pregnant Employee or Spouse/Domestic Partner Only)

(a) **Indemnity Medical Plan** – If a Participant's coverage terminates while the Participant is pregnant, the maternity benefit (i.e., benefits related to the pregnancy and delivery only) under the Indemnity Medical Plan will be provided if delivery of the baby occurs within nine months after the date the Participant's coverage terminates, unless the Participant declines the extension.

(i) In determining eligibility for this extension, the Participant's coverage termination date is determined without regard to any extensions of coverage by self-payment, Extended Coverage due to disability, unemployment, or Workers' Compensation, or COBRA.

(ii) This extension does not provide coverage to the newborn baby and is available only to the covered pregnant Employee or the pregnant Spouse or Domestic Partner of the Employee. It is not available to any other pregnant Dependents of the Employee.

(b) **HMO Plan** – If a Participant's coverage terminates while the Participant is pregnant, coverage for the pregnant Participant will be extended under the HMO Plan until the delivery of the baby or termination of the pregnancy, but in no event for more than nine months after the date the Participant's coverage terminates.

(i) In determining eligibility for this extension, the Participant's coverage termination date is determined without regard to any extensions of coverage by self-payment, Extended Coverage due to disability, unemployment, or Workers' Compensation, or COBRA.

(ii) This extension does not provide coverage to the newborn baby and is available only to the covered pregnant Employee or the pregnant Spouse or Domestic Partner of the Employee. It is not available to any other pregnant Dependents of the Employee.

(iii) To qualify for this extension of coverage, you must apply for a Maternity Benefit Extension by calling the Eligibility Department of the Fund Office prior to delivery of the baby or termination of the pregnancy. You are encouraged to contact the Fund Office as soon as you know your coverage under the Fund will terminate.

(iv) HMO coverage will be retroactive only to the extent permitted by the HMO and may be limited to less than 90 days. If unavailable through the HMO Plan, retroactive coverage will be provided through the Indemnity Medical Plan.

D. Family and Medical Leave Act (FMLA) and California Family Rights Act (CFRA)

The Family and Medical Leave Act (FMLA) requires some employers to grant employees up to 12 or 26 weeks of unpaid leave for certain specified family or medical purposes, such as the birth or adoption of a child, to provide care for a spouse, child, or parent with a serious health condition, for the employee's own illness, or because of an exigency arising from the fact that a spouse, child, or parent is on active duty in the military. In general, employers subject to FMLA are those who employ 50 or more employees. To find out more about FMLA leave and the terms on which you may be entitled to it, contact your Employer.

The California Family Rights Act (CFRA) requires many employers (generally those with five or more employees) to provide qualified employees with up to 12 weeks of unpaid leave for certain family or medical situations. For more information about CFRA leave and the terms on which you may be entitled to it, contact your Employer.

If you receive a self-payment billing statement for months during which you were on an approved FMLA or CFRA leave from your Employer, please complete the Family Leave form and submit it to the Fund Office, along with the completed copy of the self-payment billing statement that you received. You will be credited with Qualifying Hours during the period you were on FMLA and/or CFRA leave. In cases where you qualify for both FMLA and CFRA leave, the extension of your eligibility will run concurrently for up to 12 weeks.

If you are on an approved FMLA and/or CFRA leave of absence from your Employer, and you also qualify for Disability Extended Coverage or Unemployment Extended Coverage during the same absence from Covered Employment, your total period of Extended Coverage will not exceed six months.

If you are on an approved FMLA and/or CFRA leave of absence from your Employer, and you also qualify for Workers' Compensation Extended Coverage during the same absence from Covered Employment, your total period of Extended Coverage will not exceed 12 months.

While it is the responsibility of your Employer to notify the Fund Office if you take an FMLA/CFRA leave, you should, nevertheless, contact the Fund Office to notify us of your approved FMLA/CFRA leave.

California Paid Family Leave does not qualify for Extended Coverage.

E. Reserve Duty Military Leave

If you are on leave from your Employer for purposes of performing reserve duty in the Armed Forces of the United States, you will be credited with Qualifying Hours for up to one month.

7. Reestablishing Eligibility

A. If Coverage Ended due to Insufficient Hours

If your coverage ended because you did not work Qualifying Hours, and you remain in Covered Employment, you will reestablish eligibility in accordance with Section 3 ("Continuing Eligibility") of this Chapter, above.

For example: *You did not work Qualifying Hours in the February Work Month, so you lose coverage on April 30. If you then work Qualifying Hours in the March Work Month, you will be eligible for coverage in June.*

B. If Coverage Ended due to Termination of Employment

If your Covered Employment terminates, you will re-earn initial eligibility as a new Employee in accordance with the "General Initial Eligibility Rules for New Employees" (*see Section 1.A of this Chapter, above*). You must enroll for coverage and pay the applicable employee premium as if you are a new hire to re-start your coverage.

However, if you return to Covered Employment within four months after your termination date, you will reestablish eligibility under Section 3 ("Continuing Eligibility") of this Chapter, above.

C. If Coverage Ended due to Entering Military Service

If you had Fund coverage on the date you entered active military service, and you return to Covered Employment following your discharge from the military, your Fund coverage will be reinstated on the day you return to Covered Employment, provided you satisfy the requirements of USERRA and timely notify the Fund that you have returned to Covered Employment.

Among the requirements to qualify for reemployment rights under USERRA, you must:

(1) Submit an application for reemployment to your Employer within 90 days from your date of discharge, if your period of service was more than 180 days; or

(2) Submit an application for reemployment to your Employer within 14 days from your date of discharge, if your period of service was 31 days or more but less than 180 days; or

(3) Report to your Employer by the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional eight hours rest time), if your period of service was less than 31 days (or if you were absent due to a fitness for duty exam).

If you are hospitalized or convalescing from an injury caused by military service, these time limits may be extended by up to two years.

In addition to a timely application for reemployment, **you must notify the Fund Office in writing of your return to Covered Employment within 90 days of your reemployment**. Upon reinstatement, your Fund coverage will not be subject to any exclusions or waiting periods other than those that would have been imposed had your Fund coverage not terminated.

If you do not provide timely notice to the Fund Office of your return to Covered Employment, you will be required to re-earn initial eligibility as a new hire under the "General Initial Eligibility Rules for New Employees" (*see Section 1.A of this Chapter, above*).

II
ENROLLMENT

In this Chapter, the terms "you" and "your" refer to the Employee. The term "Spouse" refers to the Spouse or Domestic Partner of the Employee, unless specified otherwise.

Enrollment is required to have Fund coverage. If you do not enroll by completing the Fund's required enrollment procedures in a timely manner, you will have no right to benefits or services from the Fund.

1. Initial Enrollment

After you begin work in Covered Employment, you will receive a packet from the Fund Office informing you of your upcoming eligibility for coverage. You must complete the Enrollment Form and the Authorization for Payroll Deduction, and pay employee premiums, in order for your coverage to begin.

You must complete your enrollment within 120 days after your Initial Eligibility Date. If you fail to do so, you and your family will not be able to enroll until the next Open Enrollment, unless you or a Dependent have a Special Enrollment right.

A. Forms and Information Required for Enrollment

To enroll for coverage, you will need to submit a completed Enrollment Form and Authorization for Payroll Deduction to the Fund Office or to your Union Local Insurance Office.

You will need the following information to complete your Enrollment Form:

- Social Security Numbers. You must provide Social Security Numbers (or tax identification numbers) for you and each Dependent you want to enroll.
- Dates of Birth. You must provide your date of birth, as well as the date of birth for each Dependent you want to enroll.
- Other Insurance Coverage. You must provide information about other insurance. Specifically, you will need to have:
    - Information about other health insurance that your Spouse has access to from his or her own employer (even if your Spouse is not enrolled in the other insurance). Information needed includes the name of your Spouse's employer, the name of the employer's health insurance plan, the policy number, and contact information for the other employer and/or insurance plan.
    - Information about any other health insurance that covers you or any of your enrolled Dependents.
- Proof of Dependent Status. You must provide proof of Dependent status for each Dependent you wish to enroll and any other documents necessary to complete your Dependents' enrollment.

Below are the documents the Fund Office generally requires to establish Dependent status.

- *For a Spouse/Domestic Partner* - A copy of your marriage certificate or certified copy of the Declaration of Domestic Partnership. Marriage certificates must be certified by the County Recorder.
- *For a child* - A copy of the child's birth certificate or adoption decree. Birth certificates must be certified by the County Recorder.
- *For a child pending final adoption* - Adoption placement forms.
- *For a stepchild or a child of a Domestic Partner* - A copy of your marriage certificate or certified copy of the Declaration of Domestic Partnership and a copy of the child's birth certificate. Marriage and birth certificates must be certified by the County Recorder.
- *For a Foster Child (under a guardianship)* - The letter of guardianship (juvenile) issued by the court that appointed you or your Spouse as the child's guardian and the child's birth certificate. Contact the Fund Office for additional requirements.

Failure to Provide Proof of Dependent Status: If you fail to timely provide proof of Dependent status for any Dependent, enrollment of the Dependent may be delayed until the next Open Enrollment period. Nevertheless, you are generally permitted to temporarily enroll a Dependent while working to obtain documents required for proof of Dependent.

Dependent Social Security Numbers Needed

To comply with federal Medicare coordination of benefit regulations and certain IRS reporting rules, you must promptly furnish to the Fund the Social Security Number (SSN) of each Dependent you wish to enroll, and you must also inform the Fund whether you or any of your Dependents are currently enrolled in Medicare or have disenrolled from Medicare. This information will be requested when you first enroll for Fund coverage and may also be requested at a later date.

If a Dependent does not yet have an SSN, you can go to this website to complete a form to request one: www.socialsecurity.gov/online/ss-5.pdf. Applying for a Social Security Number is free.

Please refer to the Chapter entitled "Coordination of Benefits (COB): Other Coverage and Dual Coverage" for information on how your Fund coverage may be impacted by other insurance coverage.

B. Employee Premiums

You are required to pay a monthly employee premium for each month that you have Fund coverage. The amount of your monthly employee premium depends on which family members are covered, as shown below.

Employee premiums will generally be paid by payroll deduction. Although your employee premium is a monthly amount, most Employers withhold part of the employee premium each pay period.

Effective January 1, 2022, employee premium amounts are as follows:

Employee only coverage (no Dependents):	$34.67 per month
Employee and child(ren) (no Spouse):	$52.00 per month
Employee and Spouse (with or without children):	$69.33 per month

It takes time for the Fund Office to receive employee premiums from your Employer via payroll deductions. **To start your coverage as soon as possible, we recommend that you include a check for two months of employee premiums with your Enrollment Form.** The check should be made payable to the Southern California Drug Benefit Fund. If you submit a check for at least one month of employee premiums with your Enrollment Form, your Employee-only coverage will begin on the first of the month in which we receive your Enrollment Form and your premium payment (but no earlier than your Initial Eligibility Date). If you do not make a premium payment when you submit your Enrollment Form, your coverage effective date may be delayed by up to two months due to the lag time for the Fund Office to receive a full monthly premium payment by payroll deduction.

If you are enrolling after your Initial Eligibility Date, and you want your Fund coverage to be retroactive to your Initial Eligibility Date, you must notify the Fund Office and pay an employee premium for each month of coverage. Contact the Fund Office for assistance.

Employee premium amounts are subject to change. The Fund Office will notify you in advance of any changes in the monthly employee premium.

2. Open Enrollment

Once each year, the Fund holds an Open Enrollment period. During Open Enrollment, you can enroll yourself for coverage (if you are not yet enrolled), as well as any of your eligible Dependents. You may also change medical plans, if eligible, and you may also change your dental plan. (Most Participants are not eligible to elect an HMO Plan until the fourth annual Open Enrollment after their date of hire.)

Typically, Open Enrollment is announced in the fall. The Open Enrollment packets that are mailed to you will explain when changes become effective.

A change of plans outside of Open Enrollment and without a Special Enrollment right is generally permitted only once in a Participant's lifetime.

3. Special Enrollment

You can make certain changes outside of Open Enrollment if you or one of your Dependents has a Special Enrollment right due to a qualified life event.

A. Qualified Life Events that Trigger Special Enrollment Rights

You, your Spouse, and/or your Dependent children may be able to enroll in Fund coverage or change your plan choice(s) outside of Open Enrollment under the following circumstances:

(1) Acquisition of New Dependent – You acquire a new Dependent as a result of a marriage, registration of Domestic Partnership, birth, adoption, placement for adoption, or acquisition of a Foster Child (i.e., child under a guardianship).

(2) Eligibility for Premium Assistance – You or any of your Dependents become eligible for premium assistance with respect to Fund coverage through Medicaid or a state's Children's Health Insurance Program (CHIP), such as the California Health Insurance Premium Program (HIPP).

(3) Loss of Other Coverage – You, your Spouse, and/or your Dependent Child(ren) lose medical coverage from another group health plan or health insurance policy. This loss of other coverage must result from one of the following events:

(a) Loss of other coverage because of divorce, termination of Domestic Partnership, the loss of Dependent status under the other plan's terms, death, voluntary or involuntary termination of employment, or reduction in hours of employment (but not loss due to a voluntary termination of coverage, the failure of an employee to pay premiums on a timely basis, or termination of the other coverage for cause).

(b) You or any of your Dependents have coverage through Medicaid or a State Children's Health Insurance Program, and you or your Dependent(s) lose eligibility for that coverage.

(c) Termination of employer contributions toward other coverage (if an employer merely reduces contributions, it will not trigger a Special Enrollment right).

(d) Moving out of an HMO service area, if HMO coverage terminated as a result of the move and, for group coverage, no other option is available under the other plan.

(e) The other plan ceases to offer coverage to a group of similarly-situated individuals that includes you and/or your Dependent.

(f) The other coverage was COBRA Continuation Coverage, and such COBRA Coverage was "exhausted." COBRA Coverage is "exhausted" if it ceases for any reason other than: (i) the failure of the individual (or any other party) to pay the applicable COBRA premium on a timely basis; or (ii) for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Coverage).

Please note: Voluntarily dropping other coverage will not trigger Special Enrollment rights.

B. Deadlines for Requesting Special Enrollment and Effective Date of Enrollment

The timing of your request for Special Enrollment will affect the effective date of enrollment in Fund coverage.

(1) Within 120 Days. If you contact the Fund Office and request Special Enrollment within 120 calendar days of one of the qualified life events described above, you and/or your Dependent's new coverage will begin on the following dates (provided that the appropriate employee premiums are received by the Fund Office for each month of coverage):

- *If the event is the loss of other coverage or eligibility for premium assistance*: Coverage will begin the first day of the month following the date the event occurred.

- *If the event is the acquisition of a new Dependent*: Coverage will be retroactive to the date the event occurred.

> If you wish to cover your newborn under the Fund, you must contact the Fund Office and complete the necessary enrollment paperwork. You must enroll your newborn within 120 days of his or her date of birth for coverage to be effective retroactive to the date of birth.

If you are enrolled in one of the Fund's HMO Plans: HMO coverage will be retroactive only to the extent permitted by the HMO and may be limited to less than 90 days. If unavailable through the HMO Plan, retroactive coverage will be provided through the Indemnity Medical Plan.

(2) After 120 Days. If you request Special Enrollment more than 120 days following the event, but no later than by the end of that year's Open Enrollment period, you and/or your Dependent's new coverage will begin on the first day of the month after the Fund Office receives your Enrollment Form.

C. Individuals Eligible to Enroll upon Special Enrollment

The individual(s) seeking Special Enrollment must otherwise be eligible for Fund coverage in order to enroll.

(1) Acquisition of New Dependent – If you acquire a new Dependent, then you, your Spouse, and any newly acquired Dependent(s) may enroll.

(2) Eligibility for Premium Assistance – If you are the individual who became eligible for premium assistance, then you and any of your Dependents may enroll. If your Dependent is the individual who became eligible for premium assistance, then only you and that Dependent may enroll.

(3) Loss of Other Coverage – If you are the individual who lost other medical coverage, then you and any of your Dependents may enroll. If your Dependent is the individual who lost other coverage, then only you and that Dependent may enroll.

D. Coverage Available upon Special Enrollment

Individuals enrolled during Special Enrollment may select those plan options available to similarly-situated Employees at Initial Enrollment. The Employee and all Dependents must be enrolled in the same medical and dental plan option.

4. Recovery of Overpayments

Whenever the Fund makes a benefit payment (including premiums to an HMO Plan) that exceeds the amount it should have paid (an "overpayment"), the Fund has the right to recover the overpayment (plus interest at the same annual rate imposed for delinquent Employer contributions) from any person or organization to whom or for whom the overpayment was made or from any person whose acts, omissions, or representations caused the overpayment. In the event the Fund brings legal action to recover any overpayment, the Fund will be entitled to recover its costs and attorney's fees incurred in such action.

A notice will be sent to you and your Dependent or former Dependent if an overpayment is discovered for

which you or your Dependent is liable. Once you receive the notice, you must reimburse the Fund for the overpayment. If you are not able to repay the entire amount owed in a lump sum, you may request a payment plan to allow you to repay the debt over a reasonable period of time. Also, if you or your Dependent(s) do not reimburse the Fund, the overpayment can be offset against future benefits payable for you or your Dependents. The Board of Trustees has the discretion to waive some or all of the amount you owe if it decides that the repayment or offset of future benefits would be inequitable under the circumstances.

If you are aware of any benefits paid in error, you should notify the Fund Office in writing as soon as you discover the error. For example, benefits paid to or on behalf of your Dependents when they no longer qualify as Dependents under the terms of the Plan will be considered overpayments, and you will be required to reimburse the Fund for those benefits, including premiums the Fund paid for HMO Plan coverage.

See "Termination of Dependent Coverage" (Section 5.B of the Chapter entitled "Eligibility Rules") regarding the requirement to notify the Fund if your Dependent becomes Ineligible for Coverage.

III
CHOICE OF HEALTH PLANS

In this Chapter, the terms "you" and "your" refer to the Employee.

A. Choice of Medical Plans

The Fund provides a choice between the Indemnity Medical Plan and two HMO Plans (the Kaiser Permanente HMO and the UnitedHealthcare HMO). **However, you are not permitted to elect an HMO Plan until the fourth annual open enrollment after your most recent date of hire.**

> ***Exception***: If you gained initial eligibility under one of the "Special Initial Eligibility Rules" (described in Section 1.B of the Chapter entitled "Eligibility Rules" and in the Appendix), you may be eligible to enroll in an HMO Plan before the fourth annual Open Enrollment after your date of hire. For more information, see the Appendix at the back of this booklet.
>
> Please contact the Eligibility Department of the Fund Office for more information.

B. Choice of Dental Plans

The Fund provides a choice between the Indemnity Dental Plan and the United Concordia Dental HMO Plan. You and your Dependents must all be in the same dental plan.

C. Rules Applicable to Selection of Medical and Dental Plans

You and your Dependents must be enrolled in the same medical plan and in the same dental plan.

A change of plans outside of Open Enrollment or under a Special Enrollment right is generally permitted only once in Your lifetime.

You and your Dependents may opt out of dental and/or vision benefits, but the amount of your monthly employee premium will not change. Contact the Fund Office for more information about dropping dental and/or vision benefits.

IV
THE INDEMNITY MEDICAL PLAN

In this Chapter, the terms "you" and "your" refer to Participants, which includes both covered Employees and covered Dependents.

This Chapter applies to Participants who are covered under the Indemnity Medical Plan (referred to in this Chapter as the "Plan"). If you have coverage under one of the Fund's HMO Plans, see the Chapter of this booklet entitled "The HMO Plans" for a description of your coverage.

1. Overview

- The Indemnity Medical Plan provides benefits for covered Preventive Care Services, certain family planning services, and Medically Necessary services and supplies.

- Under the Indemnity Medical Plan, you have the freedom to use any licensed Provider you choose, but your benefits are greater when you use PPO Providers (also called In-Network Providers). When you use Non-PPO Providers (also called Out-of-Network Providers), you will generally spend more of your own money than you would by using PPO Providers.

- You are not required to designate a Primary Care Provider for yourself or your enrolled Dependents.

- When you use a PPO Provider for covered Preventive Care Services (including certain immunizations), the Fund will pay 100% of the cost of the Preventive Care Services as shown in the Plan's current Preventive Care Guidelines (available from the Fund Office). There is no Deductible, Copayment, or Coinsurance, as long as you receive the covered Preventive Care Services from a PPO Provider. (Preventive Care Services are subject to treatment, setting, frequency, and medical management criteria, which must be satisfied in order for the service or supply to be covered by the Fund at 100%. Lab tests and other services ordered by a Health Care Provider may not meet the criteria to be covered as Preventive Care Services and, therefore, may be subject to the applicable Deductible, Copay, and/or Coinsurance.)

- Before the Fund pays benefits (other than benefits for Preventive Care Services and most office visits), you must generally satisfy the annual Deductible (also known as the "Calendar Year Deductible"). The Fund has a PPO Deductible and a separate non-PPO Deductible. The expenses you pay for using a PPO Provider will apply toward the PPO Deductible. The expenses you pay for using a Non-PPO Provider, except for charges that exceed Allowed Amounts and non-covered charges, will generally apply toward the Non-PPO Deductible.

- After the Deductible is satisfied, the Fund generally pays 80% of Contract Rates if you use a PPO Provider and 50% of Allowed Amounts if you use a Non-PPO Provider. For some services and supplies, specific dollar limits are imposed that could result in the Fund paying less.

- For PPO services, once your total medical out-of-pocket expenses have reached the medical Out-of-Pocket Maximum (also called the "OOP Max"), the Fund generally will pay 100% of Contract Rates for the remainder of the calendar year. Expenses paid towards the Deductible do not count toward the OOP Max.

- There is generally no limit on out-of-pocket expenses when you use Non-PPO Providers.
- Indemnity Medical Plan enrollees have access to the Employee Assistance Program (EAP) through Anthem, which provides free help with everyday work/life challenges. For details, see the "Employee Assistance Program (EAP)" row of the Schedule of Medical Benefits for the Indemnity Medical Plan at the end of this Chapter.

2. PPO Medical Networks & Choice of Providers

When you need medical care, you have a choice between using PPO Providers and Non-PPO Providers. PPO Providers are In-Network providers that have agreements with a provider network, such as Anthem Blue Cross (in California) or BlueCard (in other states), to provide health care services and supplies at negotiated fees. Non-PPO Providers are Out-of-Network providers who have no agreement to limit the amount they charge for a service.

You are encouraged to use PPO Providers for your care. **As a general rule, you will save money by using PPO Providers.** This is because the Fund generally pays a higher level of benefits when you use PPO Providers, and a lower level of benefits when you use non-PPO Providers.

A. Medical Networks

PPO Providers have agreements with Anthem Blue Cross of California (BlueCard outside of California) under which they have agreed to provide health care services and supplies, including treatments for Mental Health and Substance Use Disorders, to Plan Participants at negotiated fees.

If you live in California, your Network of PPO Providers is the Anthem Blue Cross of California Prudent Buyer network ("Anthem"). If you or your Dependents live outside of California, or if you are traveling outside California, your PPO Network is the National BlueCard network. The BlueCard network is available in all 50 states.

Show your ID card to the Provider every time you use services so they know that you are enrolled under the Fund and where to send their bills.

B. PPO Providers (In-Network)

If you use PPO Providers, you will have lower out-of-pocket expenses. PPO Providers have agreed to accept a negotiated fee (referred to as a "Contract Rate") for covered services, and the Fund's payment is based on that negotiated fee.

When you use the services of a PPO Provider, you are responsible for paying the applicable Copayment or Coinsurance (based on the Provider's negotiated fee) for the service or supply, subject to the Deductible and any Plan limitations or exclusions. PPO Providers cannot Balance Bill you for any charges exceeding the Contract Rates.

Advantages of Using PPO Providers:

- Your annual Deductible is lower.
- The Plan pays a greater share of your covered medical expenses.
- You have Out-of-Pocket Maximums that limit your share of medical expenses each year.
- You do not have to file Claims because PPO Providers file them for you.

- Your PPO Physician or Hospital automatically handles Preauthorization and Hospital concurrent reviews.
- You generally cannot be Balance Billed.

C. Non-PPO Providers (Out-of-Network)

Non-PPO Providers are generally free to set their own charges for the services or supplies they provide, as they have not agreed to a negotiated fee. The fees of Non-PPO Providers are often higher than the Plan's Allowed Amount. When you use a Non-PPO Provider, **you are responsible for 50% Coinsurance, and you may also be responsible for any charges above the Plan's Allowed Amount** (this is known as Balance Billing). To avoid Balance Billing, Participants should use PPO Providers.

Exception: In-Network Cost Sharing (Copayments, Coinsurance, and/or Deductible, as applicable) applies to NSA Services and Out-of-Area Services. In addition, Non-PPO Providers cannot Balance Bill you for NSA Services. *For more information on these exceptions, see Section 13 ("The No Surprises Act: Protections Against Surprise Medical Bills") and Section 10 ("Out-of-Area Benefits") of this Chapter, below.*

D. Directories of PPO Providers

Electronic directories of PPO Providers are available to you without charge from Anthem Blue Cross. Links to these Provider Directories are available on the Fund's website. Please call the Fund Office if you need assistance.

- **Anthem Blue Cross Prudent Buyer Network:**

  To find a PPO Provider inside California: Visit https://ufcwdrugtrust.org/links/ or call the Fund Office at (323) 666-8910 Ext. 503 or (877) 999-8329 Ext. 503.

- **BlueCard Program Network:**

  To find a PPO Provider outside California: Call 800-810-BLUE (800-810-2583) or visit www.bcbs.com.

Because Providers are added to and dropped from the Networks throughout the year, you should ask your Provider if they are still in the Network or contact Anthem Blue Cross to verify Network status before you receive services.

If you are provided incorrect information indicating that a particular Provider is a PPO Provider, but that Provider is actually a Non-PPO Provider, and you receive services from that Provider in reliance on that information, the Fund will apply In-Network Cost Sharing (including the In-Network Deductible and OOP Max) to your Claim, to the extent required by the No Surprises Act.

3. Covered Expenses

The Plan covers most, but not all, of your expenses for medical services and supplies. The medical expenses which are covered by the Plan are called "Covered Expenses." **Covered Expenses are determined by the Plan Administrator or its designee and are limited to expenses for medical services and supplies that are:**

A. **Medically Necessary**; and

B. **Not in excess of the Allowed Amount** (for services from a Non-PPO Provider) **or the Contract**

Rate (for services from a PPO Provider); and

C. **Not excluded from coverage** (as provided in the "Excluded Services and Limitations" Chapter of this booklet); and

D. **Not in excess of a benefit maximum** (as shown in the Schedule of Medical Benefits for the Indemnity Medical Plan); and

E. **For the diagnosis or treatment of an Injury or Illness** (except when specifically covered under the Plan, such as Preventive Care Services); and

F. **Provided or ordered by a Physician or other Health Care Provider practicing within the scope of their license;** and

G. **Incurred while the Participant has coverage under the Fund.**

Generally, the Fund does not reimburse all of your Covered Expenses. Usually, you will have to satisfy a Deductible and pay Copayments and/or Coinsurance toward your Covered Expenses.

4. Medical Expenses That Are Not Covered

The Plan will not pay or reimburse you for any expenses that are not Covered Expenses. For example, you will be responsible for paying the full cost for services and supplies that are not Medically Necessary, are in excess of the Allowed Amount, are excluded from coverage, or are in excess of a benefit maximum (for example, due to the Working Spouse Rule).

In addition, most outpatient Prescription Drugs are not covered under the Indemnity Medical Plan and are, instead, covered under the Fund's Prescription Drug Program. *For more information, see the "Prescription Drug Program" Chapter of this booklet.*

5. Exclusions and Limitations

Some medical services and supplies are excluded from coverage under the Plan. The Plan will not pay benefits for those services and supplies, even if they are Medically Necessary and ordered by your Physician. Also, some services and supplies are limited to a dollar amount, visit limit, or annual allowance. The Plan will not pay more than the limit or allowance. *For more information, see the "Excluded Services and Limitations" Chapter of this booklet.*

6. Deductibles

The annual Deductible (sometimes referred to as the "Calendar Year Deductible") is the amount of Covered Expenses that you (and **not** the Fund) must pay each calendar year before the Fund begins to pay benefits. Covered Expenses are applied to Deductibles in the order in which Claims are processed by the Fund.

Note that certain services (such as most office visits) are not subject to the Deductible, which means that the Fund will pay benefits for those services before you have satisfied the Deductible, and your out-of-pocket costs for such services does not count towards the Deductible. *See Subsection B, below, for a list of services that are not subject to the Deductible.*

There are separate Deductibles for PPO and Non-PPO covered services. Expenses you pay for PPO services will generally apply towards satisfying the PPO Deductible, and expenses you pay for Non-PPO services will generally apply towards the non-PPO Deductible. **You may not use expenses for PPO services to meet the Non-PPO Deductible, nor may you use expenses for non-PPO services to meet the PPO Deductible.** However, expenses you pay for NSA Services and Out-of-Area Services will generally count towards the PPO Deductible, if a Deductible applies. *See Section 13 ("The No Surprises Act: Protections Against Surprise Medical Bills") and Section 10 ("Out-of-Area Benefits") of this Chapter, below, for more information about these exceptions.*

A. Individual and Family Deductible

There are two types of annual Deductibles: Individual and Family.

- The **individual Deductible** is the amount of Covered Expenses that one Participant must pay before the Fund begins to pay Covered Expenses for that Participant.

- The **family Deductible** is the amount of Covered Expenses that a family of two or more Participants must pay before the Fund begins to pay Covered Expenses for any Participant in the family who has not already met the individual Deductible. Once the family Deductible is met for the year, the individual Deductible does not have to be met for any remaining Participants in the family in that year.

B. Services Not Subject to the Deductible

Certain services and supplies are not subject to the Deductible. The Plan will pay benefits for those services and supplies even if you have not satisfied the individual or family Deductible. Your Cost Sharing (e.g., your Copayment) for those services and supplies does not count towards the Deductible.

<u>The following services and supplies are not subject to the Deductible:</u>

- Home health care
- Prescription Drugs
- Durable Medical Equipment
- Chiropractic care and acupuncture services
- Vision services
- The following services when received from a PPO Provider: urgent care, Physician office visits (including office visits for mental health and substance use disorder treatment), Preventive Care Services, speech therapy, and podiatry services.

In addition to the above, Copayments that you pay for inpatient Hospital admissions and charges that exceed the Allowed Amounts do not count toward satisfying the Deductible.

C. Deductible Carryover

The Deductible is accumulated on a calendar year basis. However, the amount of Covered Expenses incurred in the last three months of any given calendar year will carryover or accumulate to meet the annual Deductible for the following calendar year. This "Deductible Carryover" will be applied towards meeting the individual and family Deductibles for the following calendar year.

7. Copayments

A Copayment (sometimes called a "Copay") is a fixed dollar amount (e.g., $20) that you must pay for a covered health care service, generally when you receive the service. For example, you pay a $20 Copayment for most office visits. Copayments do not count toward your Deductible.

8. Coinsurance

Once you've met your annual Deductible, when you use a PPO Provider, you generally pay a percentage of the Contract Rate until you have met your Out-of-Pocket Maximum. If you use a Non-PPO Provider, once you've satisfied your annual Deductible, you generally pay a percentage of the Allowed Amount.

The portion of the Contract Rate/Allowed Amount that you pay is called your Coinsurance. For example, if the Fund pays 80% of a Contract Rate to a PPO Provider, you are responsible for 20% Coinsurance.

- When you use a PPO Provider, the Fund generally pays 80% of the Contract Rate, and you pay the remaining 20% as your Coinsurance.

- When you use a Non-PPO Provider, the Fund generally pays 50% of the Allowed Amount, and you pay the remaining 50% as your Coinsurance. In addition, Non-PPO Providers may charge more than the Fund's Allowed Amount. When that happens, you are generally responsible for paying your 50% Coinsurance *plus* 100% of the Non-PPO Provider's charges that exceed the Plan's Allowed Amount (called Balance Billing).

  Exceptions: For NSA Services and Out-of-Area Services, you pay the In-Network Coinsurance percentage (generally 20%). In addition, Non-PPO Providers cannot Balance Bill you for NSA Services. *For more information on these exceptions, see Section 13 ("The No Surprises Act: Protections Against Surprise Medical Bills") and Section 10 ("Out-of-Area Benefits") of this Chapter, below.*

9. The Medical Out-of-Pocket Maximum

The Plan has an annual medical Out-of-Pocket Maximum ("OOP Max") feature, which limits the amount of Covered Expenses for PPO services and supplies that you will have to pay out of your own pocket in a calendar year.

The Plan has an individual OOP Max and a family OOP Max. Cost sharing for all covered family members accumulates to the family OOP Max; however, no one individual in the family will incur out-of-pocket expenses greater than the individual OOP Max. Out-of-pocket expenses are applied to the OOP Max in the order in which Claims are processed.

Each calendar year, after an individual or family has reached the individual or family OOP Max, the Fund will pay 100% of most Covered Expenses from PPO Providers that are incurred during the rest of the calendar year (**except for** the out-of-pocket expenses you always pay, which are listed below).

The Fund's OOP Max applies only to expenses from PPO Providers. If you use Non-PPO Providers, there is no limit to your potential out-of-pocket expenses, with one exception: your Cost Sharing for NSA Services and Out-of-Area Services will be applied to the OOP Max, as if the services had been received from PPO Providers. *For more information, see Section 13 ("The No Surprises Act: Protections Against Surprise Medical Bills") and Section 10 ("Out-of-Area Benefits") of this Chapter, below*.

Expenses That You Always Pay and That Do Not Accumulate to the medical Out-of-Pocket Maximum. You (and not the Plan) are responsible for paying the following expenses, **and** these expenses do not accumulate towards the OOP Max (nor are they paid at 100% when the OOP Max is met):

- Employee premiums (also called "Employee contributions").
- Covered Expenses that accumulate toward the Deductible.
- Balance Billing.
- Health care this Plan doesn't cover.
- Your share of Covered Expenses from Non-PPO Providers, unless for NSA Services or Out-of-Area Services. *For more information, see Section 13 ("The No Surprises Act: Protections Against Surprise Medical Bills") and Section 10 ("Out-of-Area Benefits") of this Chapter, below*.
- Expenses that exceed a benefit maximum or Plan limitation.
- Expenses you pay for most outpatient Prescription Drugs, including self-injectables (these are subject to a separate Prescription Drug Out-of-Pocket Maximum, discussed in Section 11 ("Out-of-Pocket Maximum for Covered Prescription Drugs") of "Prescription Drug Program" Chapter of this booklet.
- Any amounts you owe to Providers or the Fund because of the 60% benefit reduction (financial penalty) under the Working Spouse Rule. *For more information about the Working Spouse Rule, see Section 4.E. ("The Working Spouse Rule") of the "Eligibility Rules" Chapter of this booklet*.
- Expenses for dental and vision benefits.
- Expenses for hearing aids.
- Expenses for chiropractic services.
- Expenses for acupuncture.

10. Out-of-Area Benefits

If there are no PPO Providers available to provide a Medically Necessary covered service within 50 miles of your home, the Fund pays "Out-of-Area" benefits if you receive the service from a Non-PPO Provider (referred to as "Out-of-Area Service(s)"). Please call the Fund Office if you know that you will need Out-of-Area Services, as an out-of-area Non-PPO Provider may be willing to enter into a Letter of Agreement with Anthem that would allow you to receive services on an In-Network basis. The following rules apply to Out-of-Area Services:

- The Plan applies In-Network Cost Sharing to Out-of-Area Services. This means that you will be subject to the Copayments, Coinsurance, and Deductible that apply to PPO services, but the Coinsurance for Out-of-Area Services will be determined based on the Allowed Amount rather than on Contract Rates. Non-PPO Providers may charge more than the Fund's Allowed Amount, and may Balance Bill you for charges above the Allowed Amount.

- Covered Expenses that you incur for Out-of-Area Services will apply towards your annual Out-of-Pocket Maximum, as if the services had been received from a PPO Provider.

Caution: *You can be Balance Billed by a non-PPO Provider for Out-of-Area Services if the Provider's charge is more than the Allowed Amount.*

11. Special Rules for Hospitalization

All Hospital stays and surgeries, except Emergency Services and certain maternity stays, must be Preauthorized under the Fund's Hospital review procedures. PPO Providers will handle this for you. If you use Non-PPO Providers, you are responsible for making sure that your Non-PPO Provider obtains Preauthorization. If Preauthorization is not obtained, or if you fail to comply with the Fund's other Hospital review procedures, Plan benefits may be denied pending Retrospective Review. If, based on Retrospective Review, the services are determined to be Medically Necessary and are otherwise covered by the Plan, normal Plan benefits will be paid.

12. The Utilization Management (UM) Program

Utilization Management ("UM") is a standard health plan element necessary to help control health care costs by avoiding unnecessary or excessive services or services that are more costly than others that can achieve the same result. If you follow the Plan's UM procedures and requirements, you will also avoid unnecessary out-of-pocket costs. If you don't follow these procedures, you may pay more out of your own pocket.

The Plan's UM procedures include the following:

- **Preauthorization (pre-service) Review**: Review of proposed health care services before the services are provided.
- **Concurrent (continued stay) Review**: Ongoing assessment of health care as it is being provided, typically involving inpatient confinement in a Hospital or other Health Care Facility, or review of the continued duration of health care services.
- **Retrospective (post-service) Review**: Review of health care services after they have been provided.
- **Case Management:** In some instances, a patient's needs are met better by alternative care outside a Hospital setting. The Case Management program offers alternative care options, which may include Home Health Care, Skilled Nursing Facility care, outpatient rehabilitation, and other medical approaches and settings.

These elements are discussed in more detail below.

A. Preauthorization Review

(1) How Preauthorization Review Works

Preauthorization is a procedure used to assure that health care services meet or exceed accepted standards of care and that an inpatient admission, length of stay in a Hospital, or other health care service or supply is Medically Necessary.

Preauthorization will be performed only for services and supplies for which Preauthorization is required.

If you use In-Network Providers (PPO Providers), your PPO Hospital or Physician will automatically obtain Preauthorization for you, and Anthem Blue Cross will issue you a letter with its approval or denial. If you use an Out-of-Network Provider (a Non-PPO Provider), you are

responsible for making sure Preauthorization is obtained. Your Non-PPO Provider **MUST** call Anthem or Optum Rx for Preauthorization.

(2) Services and Supplies Requiring Preauthorization

The following services and supplies must be Preauthorized BEFORE they are provided:

SERVICES AND SUPPLIES THAT MUST BE PREAUTHORIZED

The following medical services and supplies must be Preauthorized by Anthem Blue Cross:

Call ANTHEM at (800) 274-7767

1. **All elective inpatient admissions** for medical or surgical care, including hospitalizations. For pregnant women, review is required only for Hospital stays that last or are expected to last longer than 72 hours for a vaginal delivery or 120 hours for a C-section.
2. **Transplants:** A transplant should be Preauthorized as soon as the Participant is identified as a potential transplant candidate.
3. **Ambulatory Surgery Center:** All outpatient surgical procedures.
4. **Hospital outpatient surgery:** For adenoidectomy; hernia repair; obesity bypass surgery; arthroscopy of knee or shoulder; strabismus repair; carpal tunnel release; septoplasty; cataract surgery; submucous resection; diagnostic laparoscopy; tonsillectomy; varicose vein ligation; and podiatry surgery.
5. **All services and supplies listed on the Anthem Local PPO Precertification/ Prior Authorization List.** Please have your Provider call Anthem to find out whether Preauthorization is required for a particular service or supply.
6. **Durable Medical Equipment (DME)** priced at $1,000 or more
7. **Home infusion therapy**
8. **All Skilled Nursing Facility admissions**
9. **Home health care**
10. **Hospice care**
11. **Speech therapy**
12. **Certain Specialty Drugs administered in a Hospital, Health Care Facility, or Provider's Office**
13. **Penile prosthesis**
14. **Transgender Surgery -** Medical Necessity for transgender surgery will be assessed according to the Standards of Care of the World Professional Association for Transgender Health at http://www.wpath.org/.

The following mental health and substance use disorder services must be Preauthorized by Anthem Blue Cross:

Call ANTHEM at (800) 274-7767

1. **All inpatient admissions (except Emergency Services)**
2. **Residential treatment (including inpatient detoxification)Intensive outpatient treatment**
3. **Partial Hospitalization**
4. **Electro-Convulsive therapy (ECT)**
5. **Applied Behavior Analysis (ABA) therapy**
6. **Psychological testing**
7. **Neuropsychological testing**
8. **Transmagnetic Stimulation**

SPECIALTY DRUGS, including SELF-INJECTABLE MEDICATIONS, must be Preauthorized by Optum Rx.

Call Optum Rx at (800) 711-4555

PODIATRIC SURGERY (including foot surgery involving bones, bunionectomy, and hammertoe repairs) must be Preauthorized by Anthem Blue Cross:

Call ANTHEM at (800) 274-7767

Preauthorization does not guarantee payment of benefits.

Coverage depends on the services that are actually provided, your eligibility status at the time the service is provided, Plan terms, and any benefit limitations or exclusions that may apply.

(3) How to Request Preauthorization

Your Provider must call Anthem Blue Cross or Optum Rx at the telephone number shown above.

(a) Your Provider should be prepared to provide all of the following information: the Fund's name; the Employee's name; the patient's name, address, phone number, and DF number; the Physician's name and phone number or address; the name of any Hospital, outpatient facility, or any other Health Care Provider that will be providing services; the reason for the health care services or supplies; and the proposed date for performing the services or providing the supplies.

(b) If the Provider doesn't properly follow the Preauthorization process, the Provider will be notified as soon as possible, but not later than 5 calendar days, after the request.

(c) If additional information is needed, Anthem or Optum Rx will advise the Provider, review any information received, and then let the Participant and the Provider know whether the proposed health care services or supplies have been certified as Medically Necessary. Anthem or Optum Rx will usually respond to the patient's Provider **by telephone within 3 working days (but not later than 15 calendar days) after receiving the request and any required medical records and/or information**, and its determination will then be confirmed in writing.

(d) If the proposed services are not Preauthorized, you and your Provider will be given recommendations for alternative treatment. You may also pursue an appeal.

B. Concurrent Review

During an inpatient stay in a Hospital or other inpatient Health Care Facility, Anthem will monitor your stay by contacting you or your Physician to assure that continued hospitalization is Medically Necessary and to help coordinate medical care with benefits available under the Plan.

If your continued stay or services are found to be not Medically Necessary, and it is found that care could be safely and effectively delivered in another environment (such as home health or in another type of Health Care Facility), Anthem will notify you and your Physician. This does not mean that you must leave the Hospital or stop receiving services, but if you choose to stay or continue services, all expenses incurred after the notification will be your responsibility.

Emergency Hospitalization: If you require Emergency hospitalization, there may be no time to contact Anthem before the admission. If this happens, Anthem must be notified of the Hospital admission within 48 hours of the admission (you, your Dependent, the Physician, the Hospital, a family member, or a friend can make that phone call). This will enable Anthem to determine the need for continued medical services, advise the patient or the patient's Physician of the various PPO Providers and benefits available, and offer recommendations, options, and alternatives for continued medical care, and/or assistance with discharge plans.

C. Retrospective Review

Claims for medical services or supplies that were not reviewed for Preauthorization or Concurrent Review may be subject to Retrospective Review to determine if the services or supplies were Medically Necessary. If Anthem or Optum Rx determines that services or supplies were not Medically Necessary, **no benefits will be provided by the Fund for those services or supplies.**

D. Case Management

The Case Management program enables Anthem to assist you in obtaining medically appropriate care in a more economical, cost effective, and coordinated manner during prolonged periods of intensive medical care. Through case management, possible options for an alternative course of treatment are presented to you, which may include services not covered under the Plan.

The Case Management program helps coordinate services for Participants with health care needs due to serious, complex, and/or chronic health conditions.

If you meet program criteria and agree to participate, Anthem will help you meet your identified health care needs through contact and teamwork with you and/or your chosen authorized representative, treating Physicians, and other Providers. In addition, Anthem may assist in coordinating care with

existing community-based programs and services to meet your needs. This may include giving you information about external agencies and community-based programs and services.

The Case Management program is confidential, voluntary, and is provided at no extra cost to you. You are not entitled to case management services, and the Fund is not required to provide them.

E. Restrictions and Limitations of the UM Program

(1) The fact that your Physician recommends surgery or hospitalization, or proposes or provides any other medical services or supplies, does not mean that the recommended services or supplies will be covered under the Plan as a Covered Expense or Medically Necessary service.

(2) The UM Program is not intended to diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. Anthem or Optum Rx's Preauthorization of a service or supply or other certification that a service is Medically Necessary doesn't mean that a benefit payment or coverage is guaranteed. Eligibility for and payment of benefits are subject to the terms and conditions of the Plan, as described in this booklet. ***For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services are not covered by the Plan, even if they are Medically Necessary.***

(3) All treatment decisions rest with you and your Physician. You may follow whatever course of treatment you and your Physician believe to be the most appropriate, even if Anthem or Optum Rx does not Preauthorize the proposed service, supply, or hospital admission. However, the benefits payable by the Fund may be affected by the determination of Anthem or Optum Rx, as well as Plan terms.

(4) With respect to the administration of this Plan, the Fund, the Fund Office, Anthem, and Optum Rx are <u>not</u> engaged in the practice of medicine, and none of them take responsibility either for the quality of health care services actually provided (even if the services have been certified as Medically Necessary) or for the results if the patient chooses not to receive health care services that were determined not to be Medically Necessary.

F. Failure to Follow Required UM Procedures

If you don't follow the Preauthorization Review, Concurrent Review, or Case Management procedures, or if you undergo a medical procedure that has not been determined to be Medically Necessary, the Fund Office will request that the Provider ask Anthem to perform a Retrospective Review to determine if the services performed or received were Medically Necessary.

- If Anthem determines that the services were **not Medically Necessary, no Plan benefits will be payable for those services.**

- If Anthem determines that the services **were Medically Necessary**, benefits will be payable, subject to Plan terms, limitations, and exclusions.

G. Appealing a UM Determination (Appeals Process)

You may request an appeal of any adverse decision made during the Preauthorization, Concurrent Review, Retrospective Review, or Case Management process described in this Chapter. *Please see the "Claims and Appeals Procedures & the External Review Process" Chapter for more information on filing an appeal.*

13. The No Surprises Act: Protections against Surprise Medical Bills

The federal No Surprises Act (the "NSA") provides you with Cost Sharing and Balance Billing protections when certain services covered by the Plan are received from Non-PPO Providers. Covered services that are protected under the NSA are referred to in this booklet as "NSA Services."

For NSA Services:

- Your Cost Sharing (e.g., Coinsurance, Copayments, and Deductible) will be determined as if you had used a PPO Provider, but it is calculated using the "Recognized Amount" instead of Contract Rates or the Allowed Amount. The Recognized Amount is determined in accordance with the law and will generally be the lesser of the Qualifying Payment Amount (QPA) or the Non-PPO Provider's billed charges.

- You cannot be Balance Billed by the Non-PPO Provider.

- Your out-of-pocket costs will count towards your medical Out-of-Pocket Maximum (except for those expenses that you always pay, as outlined in Section 9 of this Chapter, above).

A. What are NSA Services?

There are three categories of NSA Services:

1. Emergency Services provided by Non-PPO Providers;

2. Certain Non-Emergency Services provided by Non-PPO Health Care Providers at a PPO Health Care Facility (i.e., at an In-Network Health Care Facility); and

3. Air Ambulance Services provided by Non-PPO Providers.

B. The Three Categories of NSA Services

The following provides more information on the protections applicable to each of the three categories of NSA Services.

(1) Emergency Services from Non-PPO Providers

If you receive Emergency Services from a Non-PPO Provider, the most that Provider can bill you for is your In-Network Cost Sharing (such as your In-Network Copayment, Coinsurance, and/or Deductible) for the service(s) you received. (Coinsurance is calculated using the Recognized Amount.) You cannot be Balance Billed by the Non-PPO Provider for these Emergency Services.

In addition, your out-of-pocket costs (e.g., your Coinsurance) for Emergency Services will count towards your annual medical Out-of-Pocket Maximum, in the same manner as if the services were received from a PPO Provider.

Emergency Services includes certain services you receive after you're stabilized, unless (i) you give informed written consent to give up your NSA protections for these post-stabilization services, and (ii) you are able to travel using nonmedical transportation or nonemergency medical transportation to an available PPO Provider or Facility within a reasonable distance.

Remember: *You do not need Preauthorization for Emergency Services.*

(2) Certain Non-Emergency Services from Non-PPO Health Care Providers at a PPO Health Care Facility

When you receive non-Emergency Services at a PPO Health Care Facility (i.e., an In-Network Hospital or Ambulatory Surgical Center), certain Health Care Providers there who become involved in your care may be Out-of-Network. In this situation, if you receive items and services that are otherwise covered under the Plan, the most the Non-PPO Health Care Provider can bill you for is your In-Network Cost Sharing (such as your In-Network Coinsurance and/or Deductible) for the service(s) you received. (Coinsurance for NSA Services is calculated using the Recognized Amount.)

You cannot be Balance Billed by the Non-PPO Health Care Provider for these services, unless you have given informed written consent to give up Cost Sharing and Balance Billing protections, as described below.

In addition, your out-of-pocket costs (e.g., your Coinsurance) for such services will count towards your annual medical Out-of-Pocket Maximum, in the same manner as if the services were received from a PPO Provider.

Notice and Consent to Waive NSA Protections. The protections described above will not apply, and, instead, the Plan's regular Out-of-Network Cost Sharing will apply, and you can be Balance Billed, if you give informed written consent to give up your NSA protections, as follows:

(a) At least 72 hours before the day of your appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by the NSA, that includes: (i) a statement that the provider is a Non-PPO Provider with respect to the Fund, (ii) the estimated charges for your treatment, (iii) any advance limitations that the Fund may put on your treatment (e.g., any required prior authorization), (iv) a statement that consent to receive such items and services from the Non-PPO Provider is optional, and (v) the names of PPO Providers who may be able to treat you instead; and

(b) You give informed consent to continued treatment by the Non-PPO Provider, acknowledging that you understand that continued treatment by the Non-PPO Provider may result in greater cost to you.

Limitation on Notice and Consent to Waive NSA Protections. A Non-PPO Provider may not ask you to give your Consent to Waive NSA Protections for the following items and services:

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

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

(c) Diagnostic services, including radiology and laboratory services, subject to certain exceptions;

(d) Items and services provided by a Non-PPO Provider if there was no PPO Provider who could have furnished such item or service at the PPO Health Care Facility; and

(e) Items or services furnished as a result of unforeseen, urgent medical needs that arose at the time the item or service was furnished, regardless of whether the Non-PPO Provider satisfied the notice and consent criteria.

Remember: You are *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 PPO Provider or Facility for your care.

Example: *A Participant has a covered surgery at a PPO Hospital, but the doctor who administers anesthesia to the Participant is Out-of-Network. The Participant will only be responsible for her In-Network Cost Sharing (e.g., 20% Coinsurance) and cannot be Balance Billed by the Non-PPO Anesthesiologist. The Participant's 20% Coinsurance will count towards her annual Out-of-Pocket Maximum. If she has already reached her Out-of-Pocket Maximum, then she will not have any out-of-pocket costs for services received from the Non-PPO Anesthesiologist.*

(3) Air Ambulance Services from Non-PPO Providers

If you receive Air Ambulance Services that are otherwise covered under the Plan from a Non-PPO Provider, the most the Non-PPO Provider can bill you for is your In-Network Cost Sharing (such as your In-Network Coinsurance and/or Deductible) for such services. (Coinsurance is calculated using the Recognized Amount.) You cannot be Balance Billed by the Non-PPO Provider for these services. In addition, your out-of-pocket costs (e.g., your Coinsurance) for such services will count towards your annual medical Out-of-Pocket Maximum, in the same manner as if the services were received from a PPO Provider.

14. Continued Transitional Care

If you are a undergoing a course of treatment with a PPO Provider, and there is a change in the Anthem Network so that your Provider is no longer a PPO Provider (i.e., is no longer In-Network), or if your Provider cannot continue to provide treatment to you due to a change in the terms of its contract with Anthem, you have the right to continue treatment with that Provider for up to 90 days under the same terms and conditions as before, if you qualify as a Continuing Care Patient. Under this rule, you are only permitted to receive continued transitional care from the Provider for the condition that makes you a Continuing Care Patient. This rule does not apply if the Provider's contract with Anthem is terminated due to a failure to meet applicable quality standards or for fraud.

You will qualify as a Continuing Care Patient entitled to elect continued transitional care with your Provider if:

(1) You are undergoing a course of treatment for a "serious and complex condition" (as defined below) from the Provider; or

(2) You are undergoing a course of institutional or inpatient care from the Provider; or

(3) You are scheduled to undergo nonelective surgery (including receipt of postoperative care) from the Provider; or

(4) You are pregnant and undergoing a course of treatment for the pregnancy from the Provider; or

(5) You are or were determined to be terminally ill (as determined under section 1861(dd)(3)(A) of the Social Security Act) and are receiving treatment for such illness from the Provider.

To receive this continued transitional care, you must complete a form in which you request to continue care with your Provider. If it is determined that you qualify as a Continuing Care Patient, you can then continue to receive medical care from the Provider, for the condition that makes you a Continuing Care Patient, until the earlier of: (i) 90 days from the date on which you were provided with notice of the right

to elect continued transitional care with the Provider; or (ii) the date on which you are no longer a Continuing Care Patient with respect to the Provider.

If you qualify or may qualify as a "Continuing Care Patient" with respect to a Provider who is terminated from the Anthem Network, you will be sent a notice with more information about how to apply to continue treatment with your Provider for up to 90 days.

A "serious and complex condition" means either:

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

- In the case of a chronic illness or condition, a condition that: (i) is life-threatening, degenerative, potentially disabling, or congenital; and (ii) requires specialized medical care over a prolonged period of time.

15. Participation in Approved Clinical Trials

The Plan covers your routine costs when you participate in an approved clinical trial for the treatment of cancer or other life-threatening condition (as those terms are defined below), and either:

(1) The referring health care professional is a PPO Provider who has concluded that your participation in the trial would be appropriate; or

(2) You provide the Fund Office with medical and scientific information establishing that your participation in the trial would be appropriate.

The Plan's standard benefits will apply to routine costs incurred while participating in an approved clinical trial.

You are generally required to use a PPO Provider participating in the trial. However, if the trial is only offered outside your state of residence, or if no PPO Provider will accept you, the Fund will provide coverage if you use a Non-PPO Provider participating in the trial.

For purposes of this coverage, the following definitions apply:

- "Routine costs" means services and supplies typically covered under the Plan for a Participant who is not enrolled in a clinical trial. However, such services and supplies do not include: (1) the investigational service or supply itself; (2) services and supplies that are provided solely for data collection and analysis purposes and not for the direct clinical management of the patient; or (3) a service or supply inconsistent with widely accepted and established standards of care for the particular diagnosis.

- An "approved clinical trial" is a phase I, II, III, or IV clinical trial that is conducted in connection with the prevention, detection, or treatment of cancer or other life-threatening condition and is: (1) federally funded or approved by a variety of entities or departments of the federal government; (2) conducted in connection with an investigational new drug application reviewed by the U.S. Food and Drug Administration; or (3) exempt from investigational new drug application requirements

- A "life-threatening condition" is a disease or condition likely to result in death unless the disease or condition is interrupted.

If you wish to participate in a clinical trial, you should contact the Fund Office for more information and to make sure you meet the requirements for coverage. In addition, Preauthorization by Anthem is required for inpatient services.

16. Schedule of Medical Benefits

A schedule of the Plan's medical benefits appears on the following chart. This schedule outlines Deductibles, Out-of-Pocket Maximums, and specific covered services and exclusions. Inpatient Hospital services and Physician and other Health Care Provider services are listed first because these services are generally used the most. Other benefits are listed in alphabetical order.

TIME LIMIT FOR FILING OF HEALTH CLAIMS

All Claims must be filed within one year from the date of service. Claims filed more than one year after the date of service will be denied.

If you use a PPO Provider, and the PPO Provider does not file a Claim on time, the most the PPO Provider can charge you is the cost-sharing you would have been responsible for if the Provider had timely filed a Claim.

SCHEDULE OF MEDICAL BENEFITS FOR THE INDEMNITY MEDICAL PLAN

This chart explains the benefits payable under the Plan and your Cost Sharing requirements. See the "Definitions" Chapter of this booklet for definitions of the capitalized terms used in this chart and the "Excluded Services and Limitations" Chapter of this booklet for details on what this Plan does not cover.

IMPORTANT: Non-PPO Providers generally charge more than the Allowed Amount. If this happens, you may be responsible for your Coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Calendar Year Deductible ("Deductible")	• The Deductible may not be satisfied by Copayments (including the Hospital admission Copay) or by charges that exceed the Fund's Allowed Amounts. • Only Covered Expenses that are subject to the Deductible will count towards the Deductible. • Certain Covered Expenses are not subject to the Deductible, including Home Health Care, Prescription Drugs, durable medical equipment, chiropractic care and acupuncture services, vision services, and the following services when received from a PPO Provider: urgent care, Physician office visits (including office visits for Mental Health and Substance Use Disorder treatment), Preventive Care, speech therapy, and podiatry. • **Note:** The PPO Deductible does not accumulate to the medical Out-of-Pocket Maximum. However, the combined limits on Cost Sharing (Deductible and Out-of-Pocket Maximums) comply with the Cost Sharing limitations of the Affordable Care Act (ACA).	$300/Individual $600/Family	**Gold Plan:** $2,000/Individual $4,000/Family **Platinum Plan:** $1,000/Individual $2,000/Family
Medical Out-of-Pocket Maximum ("OOP Max")	• The following expenses do not accumulate towards the medical OOP Max (and are not paid by the Fund at 100% when the OOP Max is met): Premiums, non-Covered Expenses, expenses that exceed a benefit maximum or Plan limitation, Covered Expenses that accumulate towards your Deductible, Balance Billing, expenses from Non-PPO Providers (except for Covered Expenses for NSA Services and Out-of-Area Services), expenses you pay due to the 60% benefit reduction (financial penalty) under the Working Spouse Rule, and expenses you pay for most Prescription Drugs (including self-injectables), vision care, dental care, hearing aids, chiropractic care, and acupuncture. • There is a separate Out-of-Pocket Maximum for In-Network Prescription Drugs (called the Prescription Drug Out-of-Pocket Maximum or Rx OOP Max). See the "Prescription Drug Program" Chapter for more information.	After the Deductible: $2,000/Individual $6,000/Family	None

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IMPORTANT: Non-PPO Providers generally charge more than the Allowed Amount. If this happens, you may be responsible for your Coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Out-of-Area Services ("OOA Services") If there are no PPO Providers available to provide a Medically Necessary covered service within 50 miles of your home, the Fund pays "Out-of-Area" benefits if you obtain the service from a Non-PPO Provider.	• For Out-of-Area Services, you are responsible for the In-Network Deductible, Copayment amount, and/or Coinsurance percentage that would apply if the OOA Service was provided by an In-Network Provider. • Please call the Fund Office if you know that you need OOA Services, as your out-of-area Non-PPO Provider may be willing to enter into a letter of agreement with Anthem that would allow you to obtain services on an In-Network basis. • Covered Expenses that you incur will apply towards the annual Out-of-Pocket Maximum, as if the services had been received from a PPO Provider. However, you can be Balanced Billed for charges above the Allowed Amount, and such expenses are not subject to the OOP Maximum.	Not applicable	Subject to in-Network Deductible if the Deductible would apply In-Network. In-Network Coinsurance percentages and/or Copayments (as applicable) apply. Non-PPO Providers can Balance Bill you for OOA Services if the Allowed Amount is less than the Provider's billed charge.
Services Subject to the No Surprises Act ("NSA Services")	• Applicable to Out-of-Network Emergency Services, certain non-Emergency Services furnished by Out-of-Network Health Care Providers at In-Network Health Facilities, and Out-of-Network Air Ambulance services.	Not applicable	In-Network Coinsurance percentages and Copayments (as applicable) apply to NSA Services. In addition, NSA Services are subject to the PPO (In-Network) Deductible and the OOP Max, and you cannot be Balance Billed.

SCHEDULE OF MEDICAL BENEFITS FOR THE INDEMNITY MEDICAL PLAN

This chart explains the benefits payable under the Plan and your Cost Sharing requirements. See the "Definitions" Chapter of this booklet for definitions of the capitalized terms used in this chart and the "Excluded Services and Limitations" Chapter of this booklet for details on what this Plan does not cover.

IMPORTANT: Non-PPO Providers generally charge more than the Allowed Amount. If this happens, you may be responsible for your Coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Hospital Services (Inpatient Facility) Covered services include: • Hospital Room with two or more beds unless a private room is determined to be Medically Necessary. • Care in a Special Care Unit, such as Intensive Care (ICU) or Coronary Care (CCU). • Operating, delivery, and special treatment rooms. • Alternative birthing centers. • Drugs, medicines, oxygen, blood, and blood products given to the patient during the Hospital stay. • Lab/x-ray/diagnostic services while inpatient.	• **Preauthorization is required for all hospitalizations, except childbirth and Emergency Services.** • **If you use a Non-PPO Hospital, you need to get Preauthorization from Anthem Blue Cross (PPO Providers will automatically handle this for you).** • If your Hospital admission is for Emergency Services, Anthem Blue Cross must be notified of the Hospital admission within 48 hours of your admission. • If your Hospital admission is for childbirth, and your hospital stay will be more than 48 hours (for vaginal delivery) or 96 hours (for C-section), Anthem Blue Cross must be notified of the stay. • The Plan does not cover Hospital admissions and surgeries that are not Medically Necessary. • Personal items provided in a Hospital and take home drugs when discharged from the Hospital are not covered.	After the Deductible and $100 Copay per admission, the Fund pays 80% of Contract Rates.	After the Deductible and $100 Copay per admission, the Fund pays 50% of the Allowed Amount.
Hospital Services (Outpatient Facility)	• Many outpatient surgeries require Preauthorization. See Section 12.A(2) of this Chapter, above, for a list of outpatient surgeries for which Preauthorization is required.	After the Deductible, the Fund pays 80% of Contract Rates.	After the Deductible, the Fund pays 50% of the Allowed Amount.

SCHEDULE OF MEDICAL BENEFITS FOR THE INDEMNITY MEDICAL PLAN

This chart explains the benefits payable under the Plan and your Cost Sharing requirements. See the "Definitions" Chapter of this booklet for definitions of the capitalized terms used in this chart and the "Excluded Services and Limitations" Chapter of this booklet for details on what this Plan does not cover.

IMPORTANT: Non-PPO Providers generally charge more than the Allowed Amount. If this happens, you may be responsible for your Coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Physician and Other Health Care Provider Services • Benefits are payable for professional fees when covered services are provided by a Physician or other Health Care Provider. • Physician office visits (primary care and specialist).	• All inpatient and most outpatient surgeries require Preauthorization. See Section 12.A of this Chapter, above, for more information about services requiring Preauthorization. • Telehealth visits available only In-Network through Anthem • Telehealth visits not covered Out-of-Network.	**Physician Hospital visits, surgeon, assistant surgeon, and anesthetist/anesthesiologist:** After the Deductible, the Fund pays 80% of Contract Rates. **Office Visits:** $20 Copay/visit, not subject to the Deductible. **Telehealth Visits:** $0 copay through Anthem LiveHealth Online; otherwise $20 Copay/visit, not subject to the Deductible.	**Physician Hospital visits, surgeon, assistant surgeon, and anesthetist/anesthesiologist:** After the Deductible, the Fund pays 50% of the Allowed Amount. **Office Visits:** After the Deductible, the Fund pays 50% of the Allowed Amount. **Telehealth Visits:** Not covered. NSA Services subject to In-Network level of benefits. See NSA Services row for information.
Acupuncture/Chiropractic Care	• There is a combined benefit limit for chiropractic/spinal manipulation, acupuncture, and acupressure services for each covered Participant. • Plan benefits limited to no more than (i) one visit per day, up to a combined maximum of $500 per calendar year for office visits; and (ii) $150 per calendar year for x-ray and laboratory.	Not subject to the Deductible. Plan pays a $25.50 benefit per visit.	
Ambulance Services	• Ground ambulance services are covered for Medically Necessary transportation to or from the nearest Hospital or appropriate facility only when Participant is confined as a bed patient, or for an accident, Emergency, or acute Illness. • Ambulance services for transportation primarily to suit the patient's or Physician's convenience are not covered. • Paramedic services when the patient is not transported to a Hospital are not covered. • Ground ambulance services are not NSA Services. • Air/sea Emergency transportation is covered only as Medically Necessary due to inaccessibility by ground transport and/or if the use of ground transport would be detrimental to the patient's health status.	After the Deductible, 80% of the Contract Rate if admitted or for an Emergency Medical Condition; otherwise 50% of the Contract Rate.	After the Deductible, 80% of the Allowed Amount if admitted or for an Emergency Medical Condition; otherwise 50% of the Allowed Amount. **Non-PPO Air Ambulance** services are subject to the NSA. See NSA Services row for more information on Non-PPO Air Ambulance benefits.

SCHEDULE OF MEDICAL BENEFITS FOR THE INDEMNITY MEDICAL PLAN

This chart explains the benefits payable under the Plan and your Cost Sharing requirements. See the "Definitions" Chapter of this booklet for definitions of the capitalized terms used in this chart and the "Excluded Services and Limitations" Chapter of this booklet for details on what this Plan does not cover.

IMPORTANT: Non-PPO Providers generally charge more than the Allowed Amount. If this happens, you may be responsible for your Coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Artificial Limbs & Orthopedic Appliances Coverage for Medically Necessary artificial limbs and Orthopedic Appliances: • Purchase or repair of artificial limbs, but not during the 12-month period following the date of purchase. • Purchase or rental of Orthopedic appliances and replacements up to once a year (or more if Medically Necessary).	• Rental charges that exceed the reasonable purchase price of the equipment are not covered. • Support stockings, elastic stockings, crutches, walking canes, and trusses are not covered as Orthopedic Appliances (and are not paid at 100%). • Repairs of artificial limbs or Orthopedic Appliances during the 12-month period following the date of purchase are not covered. • Orthopedic Appliances limited to purchase or rental up to once every calendar year if prescribed by a Physician. • If a Participant's coverage under the Fund is terminated and an artificial limb or orthopedic appliance is required as a result of a disability which was incurred while the patient had coverage under the Fund, this benefit will be provided during the 12-month period following the date of loss of coverage under the Fund, if the patient continues to be disabled.	**Artificial Limbs:** After the Deductible, Plan pays 100% of Contract Rates. **Orthopedic Appliances:** Plan pays 100% of Contract Rates, not subject to the Deductible.	**Artificial Limbs:** After the Deductible, Plan pays 100% of the Allowed Amount. **Orthopedic Appliances:** Plan pays 100% of the Allowed Amount, not subject to the Deductible.
Chiropractic Care/Acupuncture	• There is a combined benefit limit for chiropractic/spinal manipulation, acupuncture, and acupressure services for each covered Participant. • Plan benefits limited to no more than (i) one visit per day, up to a combined maximum of $500 per calendar year for office visits; and (ii) $150 per calendar year for x-ray and laboratory.	Not subject to the Deductible. Plan pays a $25.50 benefit per visit.	
Clinical Trials	Plan covers routine costs of participation in an approved clinical trial for the treatment of cancer or other life-threatening condition as described in Section 15 ("Participation in Approved Clinical Trials") of this Chapter, above.	The Plan's standard benefits apply.	

SCHEDULE OF MEDICAL BENEFITS FOR THE INDEMNITY MEDICAL PLAN

This chart explains the benefits payable under the Plan and your Cost Sharing requirements. See the "Definitions" Chapter of this booklet for definitions of the capitalized terms used in this chart and the "Excluded Services and Limitations" Chapter of this booklet for details on what this Plan does not cover.

IMPORTANT: Non-PPO Providers generally charge more than the Allowed Amount. If this happens, you may be responsible for your Coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Durable Medical Equipment (DME) & Medical Supplies Coverage is provided for Medically Necessary DME and medical supplies	• Rental charges that exceed the reasonable purchase price of the equipment are not covered. • Equipment for exercise, environmental control, or primarily for the patient's comfort or hygiene is not covered. • Blood glucose monitors covered as DME. • Must be ordered by a Physician or other Health Care Provider, be of no further use when medical need ends, be usable only by the patient, and manufactured specifically for medical use. • For the duration of breastfeeding, coverage for one standard manual or electric breast pump (plus supplies to operate the breast pump) if purchased through a PPO durable medical equipment ("DME") vendor.	**Breast Pump:** Plan pays 100% of the Contract Rate, not subject to the Deductible. Breast pump must be purchased from licensed DME provider. **Durable Medical Equipment:** Plan pays 80% of Contract Rates, not subject to the Deductible. **Outpatient Medical & Surgical Supplies:** After the Deductible, Plan pays 80% of Contract Rates.	**Breast Pump:** Not covered **Durable Medical Equipment:** Plan pays 80% of the Allowed Amount, not subject to the Deductible. **Outpatient Medical & Surgical Supplies:** After the Deductible, Plan pays 50% of the Allowed Amount.
Emergency Room Services (Facility, Physician and Ancillary Services) Hospital Emergency Room (ER)	• There is no Preauthorization requirement for Emergency Services. However, if a Participant requires Emergency hospitalization, Anthem Blue Cross must be notified within 48 hours of the Hospital admission. • Do not use an Emergency Room for routine office visits or non-Emergency situations or benefits may be denied.	After the Deductible, the Fund pays 80% of Contract Rates.	After the Deductible, the Fund pays 80% of the Allowed Amount for Emergency Services; otherwise, 50% of the Allowed Amount. **Non-PPO Emergency Services** are subject to the NSA. See NSA Services row for information about benefits for Non-PPO Emergency Services.
Employee Assistance Program (EAP) Provides help 24/7 when you experience emotional distress (such as anxiety, stress, grief, depression) or struggle with everyday challenges	• The EAP connects you to licensed mental health professionals who will listen and help you address the demands of daily work/life challenges, such as financial and legal issues, mental health, substance abuse, relationship (marital, parenting, work, etc.) challenges, loss of a loved one, elder care and childcare. • Limited to 3 sessions per issue per calendar year. Once you have reached this limit, no additional sessions will be covered. • To access EAP services, call (800) 999-7222 or go to anthem.com/CA/EAP and use the code "So CA Drug" to log in.	No charge	Not covered

SCHEDULE OF MEDICAL BENEFITS FOR THE INDEMNITY MEDICAL PLAN

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Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Family Planning, Reproductive, Contraceptive Services • Sterilization services (e.g., vasectomy, tubal ligation, implants). • Contraceptive devices. • Limited fertility and infertility services.	• No coverage for any expenses connected with any form of artificial insemination, non-surgical treatment for infertility after diagnosis, or the reversal of voluntary infertility/sterilization. • No coverage for any expenses connected with or resulting from surrogate mothers or sperm banks. • When a generic contraceptive device is available, only the generic is covered with no Cost Sharing, unless the generic is medically inappropriate. • Contraceptive drugs, such as birth control pills, and erectile dysfunction drugs are covered under the Prescription Drug Program.	**Female sterilization and FDA-approved contraceptive devices:** Covered as Preventive Care Services at 100%, not subject to the Deductible. **All others:** After the Deductible, the Fund pays 80% of Contract Rates.	**Female sterilization and FDA-approved contraceptive devices:** Not covered. **All others:** After the Deductible, the Fund pays 50% of Allowed Amount.
Hearing Aids Covers Physician examination and external hearing aid for patients whose Physician has certified a hearing loss that may be lessened by the use of a hearing aid.	**Hearing Aids:** The hearing aid benefit is NOT provided under the following circumstances: • The Physician's exam is made without an instrument being purchased. • Replacement of instruments for any reason more often than once during any 12-month period. • Reimbursement for batteries or ancillary equipment, unless obtained with the initial purchase of the equipment. • Reimbursement for repairs, servicing, or alteration of the hearing aid.	Plan pays 80% of the Allowed Amount for the Physician exam and instrument, up to a maximum of $750 per ear in any 12-month period.	
Home Health Services • Part-time, intermittent skilled nursing care services and Medically Necessary supplies to provide Home Health Care or home infusion services. • Supplies needed for use by skilled home health or home infusion personnel are covered, but only during the course of their required services. • Services and supplies provided in lieu of the services that would have been covered under the Plan if confinement had been in a Hospital or Skilled Nursing Facility are covered.	• Preauthorization by Anthem Blue Cross is required. **(PPO Providers will automatically handle this for you).** • Coverage is provided for nursing care in the home or home infusion therapy when ordered by a Physician as being Medically Necessary. • Custodial care and homemaker services are not covered. • Physical therapy and occupational therapy visits provided in the home count toward and are subject to the 25 visit per calendar year limit applicable to outpatient physical and occupational therapy.	Plan pays 80% of Contract Rates, not subject to the Deductible.	Plan pays 80% of the Allowed Amount, not subject to the Deductible.

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Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Hospice Hospice services include inpatient Hospice care and outpatient home hospice for a terminally ill patient.	• Preauthorization by Anthem Blue Cross is required. **(PPO Providers will handle this for you).**	Plan pays 80% of Contract Rates, not subject to the Deductible.	Plan pays 50% of the Allowed Amount, not subject to the Deductible.
Laboratory Services (Outpatient) Includes technical and professional fees.	• Covered only when ordered by a Physician or Health Care Provider. • For coverage of inpatient laboratory services, see the Hospital Services row. • Some laboratory services may be payable as Preventive Care. See the Preventive Care Services row for more information.	After the Deductible, the Fund pays 80% of Contract Rates.	After the Deductible, the Fund pays 50% of the Allowed Amount.
Maternity Services • Hospital and Birthing Center charges and Physician and Certified Nurse Midwife fees. The following maternity-related services and supplies are payable as Preventive Care Services: • Breastfeeding equipment (breast pump) and supplies needed to operate the pump, as outlined in the "Medical Supplies & Equipment" row of this Schedule. • Lactation support and counseling (including breastfeeding classes) by a trained PPO Provider during pregnancy and/or in the postpartum period.	• Maternity care is covered for Participant who is a female Employee, Spouse, or Domestic Partner only. **No coverage is provided for maternity/delivery expenses of Dependent children** (except for certain Preventive Care Services and Emergency Services as mandated by law). • Surrogate pregnancies and all related charges (both when the surrogacy is for a Participant and when a Participant is the surrogate) are not covered. The only exception is that certain Preventive Care Services screenings are covered for any pregnant Participant. • In accordance with federal law, the Plan generally may not restrict benefits for any Hospital length of stay in connection with childbirth for the mother or the newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. This Plan does not prohibit the attending Provider, after consultation with the mother, from discharging the mother or her newborn earlier, in which case the Fund may pay for a shorter stay. In any case, the Fund may not require that a Provider obtain authorization for prescribing a length of stay of up to 48 hours (or 96 hours).	**Lactation support and counseling:** Covered at 100%, not subject to the Deductible. **Maternity Inpatient Admission:** After the Deductible and $100 Copay/admission, the Fund pays 80% of Contract Rates. **Office Visits:** $20 Copay/visit, not subject to the Deductible. **All other:** Plan pays 80% of Contract Rates.	**Lactation support and counseling:** Not covered. **Maternity Inpatient Admission:** After the Deductible and $100 Copay/admission, the Fund pays 50% of the Allowed Amount. **Office Visits:** After the Deductible, the Fund pays 50% of the Allowed Amount. **All other:** Plan pays 50% of the Allowed Amount.

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Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Mental Health and Substance Use Disorder Treatment Mental Health and Substance Use Disorder benefits are administered by Anthem Blue Cross. Inpatient and outpatient behavioral health treatment, including outpatient therapy and residential treatment, are available through the Anthem Blue Cross Prudent Buyer Network.	• For Mental Health and Substance Use Disorder services, the **PPO Network of Health Care Providers and facilities is provided by Anthem Blue Cross**. • To receive PPO level benefits, you must use an Anthem Blue Cross contracted Provider. • Preauthorization is required for: all inpatient admissions (except Emergency hospitalization), inpatient rehabilitation, residential treatment programs (including inpatient detox), partial hospitalization, ECT, psychological testing, Applied Behavioral Analysis (ABA) therapy, transmagnetic stimulation, and neuropsychological testing, each of which are designated as "inpatient" services under the Fund. • When Anthem Blue Cross coordinates the admission, Preauthorization is done for you. • Outpatient Prescription Drugs are payable under the Prescription Drug Program.	**Inpatient:** After the Deductible, the Fund pays 80% of Contract Rates. **Outpatient office visits:** $20 Copay/visit, not subject to the Deductible. **Other services:** After the Deductible, the Fund pays 80% of Contract Rates.	After the Deductible, the Fund pays 50% of the Allowed Amount.
Outpatient Surgery Centers / Ambulatory Surgery Centers Facility Fees for Outpatient Surgery Center (aka Ambulatory Surgery Center). See the "Physician and Other Health Care Provider Services" row for coverage of Physician/Surgeon fees	• **Must be Preauthorized by Anthem Blue Cross.** • If you use a Non-PPO Outpatient Surgical Center, you must have your Provider call Anthem Blue Cross for Preauthorization (PPO Providers will automatically handle this for you). • **Benefits at a Non-PPO facility are limited to a maximum of $350 per operative session.** Any charges in excess of this $350 maximum do not count toward the Deductible.	After the Deductible, the Fund pays 80% of Contract Rates	After the Deductible, the Fund pays 50% of the Allowed Amount, up to a maximum of $350 per operative session. You are responsible for all charges above the $350.
Orthopedic Appliances	See row for "Artificial Limbs & Orthopedic Appliances" above.		
Physical Therapy & Occupational Therapy (Outpatient) Coverage for physical therapy & occupational therapy (for rehabilitative and habilitative purposes).	• Outpatient physical therapy and occupational therapy ("PT/OT") and PT/OT provided in the home are limited to a combined maximum of 25 visits per calendar year. • Once you have reached the 25-visit maximum for PT/OT, no additional visits will be covered, even if Medically Necessary.	After the Deductible, the Fund pays 80% of Contract Rates.	After the Deductible, the Fund pays 50% of the Allowed Amount.

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Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Podiatry Services Provides for the assessment, diagnosis, and management of the foot and lower limb related problems. Coverage includes services, devices, special footwear, Orthotics, braces, and supplies approved by Anthem Blue Cross. and provided by a PPO Provider.	• Podiatry benefits are provided through the Anthem Blue Cross of California Prudent Buyer network. • ***Inside California:*** You are required to use PPO Providers or there is no coverage. • ***Outside California:*** You are required to use BlueCard Network Providers for covered services or there is no coverage. Benefits are limited to 8 office visits per calendar year. • The Fund covers one pair of custom-molded shoes per lifetime for diabetics.	You pay $65 for the first office visit, unless the visit is for Emergency, trauma, or a diabetic condition. After the first visit, the Fund pays 100% of Contract Rates. Limited to a maximum of 8 visits per calendar year. Not subject to the Deductible.	Not covered.
	Special Podiatry Benefit: The benefit is for office calls and charges (including x-rays) by Non-PPO Providers incurred for the non-surgical treatment of chronic foot conditions, such as weak or fallen arches, flat or pronated feet, hallux valgus, metatarsalgia, or foot strain, and toenail trimming and surgical treatment involving debridement of painful clavi.	Not applicable.	A separate $120 per calendar year benefit is available regardless of whether you are enrolled in the Indemnity Medical Plan or an HMO Plan.

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Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Radiology (X-Ray), Nuclear Medicine, Imaging Studies, and Radiation Therapy Services (Outpatient) • Radiology refers to the branch of medicine using x-rays, radiopharmaceuticals (like radioisotopes, intravenous dye, or contrast materials), magnetic resonance, and ultrasound to create images (pictures) of the body that are used to help in the diagnosis and treatment of disease or injury. • Common radiology services include chest x-ray, abdomen/kidney x-ray, spine x-ray, CT/MRI/PET and bone scans, ultrasound, angiography, mammogram, bone densitometry and fluoroscopy (mammogram and bone densitometry may be covered under Preventive Care Services). • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Provider and Medically Necessary. • Some services may require Preauthorization by Anthem Blue Cross. Please contact Anthem if you would like to know whether a particular service requires Preauthorization.	After the Deductible, the Fund pays 80% of Contract Rates.	After the Deductible, the Fund pays 50% of the Allowed Amount.

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Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Reconstructive Services and Breast Reconstruction after Mastectomy This Plan complies with the **Women's Health and Cancer Rights Act** (WHCRA), which requires that for any covered individual who is receiving benefits under the Plan in connection with a mastectomy and who elects breast reconstruction, coverage will be provided in a manner determined in consultation with the attending Physician and the patient for: • All stages of reconstruction of the breast on which the mastectomy was performed; • Surgery and reconstruction of the other breast to produce a symmetrical appearance; • Prostheses; and • Treatment of physical complications of the mastectomy, including lymphedemas.	• Preauthorization by Anthem Blue Cross is required. **(PPO Providers will automatically handle this for you).** • If you use a Non-PPO Provider, you must have your Provider call Anthem Blue Cross for Preauthorization. • These benefits will be provided subject to the same Deductibles, Copayments, and Coinsurance applicable to other medical and surgical benefits provided under the Plan.	After Deductible, the Fund pays 80% of Contract Rates.	After Deductible, the Fund pays 50% of the Allowed Amount. However, if the services are provided by an Outpatient Surgery Center, facility benefits are limited to a maximum of $350 per operative session.
Skilled Nursing Facility (SNF) (Medicare approved) • Services must be ordered by a Physician or Health Care Provider and must be Medically Necessary. • SNF stay must follow a hospitalization.	• **Must be Preauthorized by Anthem Blue Cross.** • Care in a Skilled Nursing Facility is limited to 240 days per disability. • Custodial care is not covered. • Skilled nursing services provided in the home are payable under "Home Health Services." • Facility must be a Medicare-certified provider.	After the Deductible, the Fund pays 80% of Contract Rates.	After the Deductible, the Fund pays 50% of the Allowed Amount.

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Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Special Accident Benefit Maximum of $300 payable towards Covered Expenses for services and supplies received by a Participant within 90 days of an accident as a result of the accident.	• Available without regard to whether the Participant was covered under the Plan at the time of the accident (though the Participant must be covered under the Plan at the time the Covered Expenses are incurred) • Payable toward reasonable charges for medically necessary services or supplies not otherwise reimbursed under Plan for treatment of accidental injury • Payable only for charges incurred within 90 days of accidental injury	Up to $300 per accident	
Speech Therapy Coverage for speech therapy (for rehabilitative and habilitative purposes)	• **Preauthorization is required.** • Limited to 24 visits per calendar year. Once you have reached the 24-visit maximum, no additional visits will be covered, even if Medically Necessary. • You must use PPO Providers or there is no coverage.	$20 Copay/visit, not subject to the Deductible.	Not covered.
TMJ Services • Medically Necessary treatment of Temporomandibular joint (TMJ) dysfunction or syndrome.	• See the "Hospital Services (Inpatient Facility)" row for facility benefits if hospitalization is required. • A maximum of $500 is allowed for the non-surgical treatment of TMJ within any 12-month period. • A lifetime maximum of $2,000 is allowed for the surgical correction of TMJ problems by an oral surgeon. Amounts paid for non-surgical treatment of TMJ will reduce the $2,000 available for surgical correction.	If treatment is Preauthorized as Medically Necessary, a lifetime maximum of $2,000 will be allowed for the surgical correction of a TMJ problem by an oral surgeon, and up to $500 will be paid for the non-surgical treatment of TMJ within any 12-month period. Amounts paid for the non-surgical treatment of TMJ will reduce the $2,000 available for any later surgical correction.	

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Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Transplants (Organ and Tissue) • Coverage is provided only for services directly related to Medically Necessary and non-Experimental transplants, along with facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.	• **Covered only if the transplant is performed at an Anthem Blue Cross-approved Center of Excellence, and the transplant is Preauthorized by Anthem Blue Cross.** However, cornea transplants are not subject to Preauthorization. • **The transplant recipient must be a Plan Participant for a transplant or any donor expenses to be covered.** • Reasonable and necessary medical expenses incurred by a live donor who is a Participant are payable without Deductible or Coinsurance, but only if the transplant recipient is also a Plan Participant. • Reasonable and necessary medical expenses incurred by a live donor who is not a Participant are payable without Deductible or Coinsurance, but only to the extent they are not covered by the donor's own insurance or health plan. Complications directly related to the donation are also covered but only to the extent they are not covered by the donor's own insurance or health plan, and then not beyond 3 months. • Donor search, organ or tissue procurement, and non-medical donor expenses are covered up to a combined lifetime maximum of $30,000, so long as such expenses are not covered by the donor's own medical coverage or health plan. • A lifetime benefit for Transplant related travel expenses of up to $5,000 will be reimbursed for the Transplant-recipient and one family member or companion if the Preauthorized transplant will be performed more than 150 miles from the Transplant-recipient's home.	After the Deductible, the Fund pays 80% of Contract Rates.	Not covered.
Urgent Care Facility	• Use of an urgent care facility is appropriate if you don't have a regular doctor, your doctor's office is closed, or if you need care when you are away from home. Urgent care facilities usually are not used for Emergency Services.	$20 Copay/visit, not subject to the Deductible.	After the Deductible, the Fund pays 50% of the Allowed Amount.

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Benefit Description	Explanations and Limitations of Benefits	Gold Plan and Platinum Plan Benefits	
		PPO	Non-PPO
Vision Services Plan benefits may be used towards routine eye exams, frames, and lenses (including contact lenses).	• For vision benefits to be provided, you must submit a completed Vision Claim Form along with an itemized bill, valid prescription for frames & materials, and a cash register receipt. • Payment for prescription lenses will be made only if a valid prescription is presented to the Fund as part of your Claim. • Unused vision benefits from the previous year are rolled over for use in the current calendar year, but no more than $135 from a prior year can be rolled into any calendar year. • *Note: You are permitted to opt-out of vision coverage for yourself and your Dependents. However, opting out of vision benefits will not change the amount of your Employee Contribution/Premiums.*	**Pediatric Vision Care (up to age 19):** Routine eye exams are covered at 100%, up to $135 per exam. However, amounts paid for routine eye exams will reduce the annual $135 maximum benefit for frame and lenses. **Adult Vision Care (age 19 and over):** Routine eye exams and frames/lenses are covered at 100% up to $135 per calendar year for exam and materials combined.	

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Benefit Description & Explanation and Limitations of Benefits	Gold Plan and Platinum Plan Benefits
Preventive Care Services for Men, Women, and Children The Preventive Care Services covered by this Plan are designed to comply with Affordable Care Act (ACA) regulations and the current A and B recommendations of the United States Preventive Services Task Force (USPSTF), the Health Resources and Services Administration (HRSA), Bright Futures/American Academy of Pediatrics, and the Centers for Disease Control & Prevention (CDC). **Please note:** • When both Preventive Care Services and diagnostic or therapeutic services occur at the same visit, you pay the Cost Sharing for the diagnostic or therapeutic services but not for the Preventive Care Services. • If a Preventive Care Service is billed separately from an office visit, the office visit is subject to normal Plan benefits (e.g., Cost Sharing requirements such as a Copayment). • If a Preventive Care Service is not billed separately from the office visit, and the office visit is primarily for the purpose of providing Preventive Care Services, the office visit is payable at 100%. If the main purpose of the office visit is not for the purpose of providing Preventive Care Services, normal Plan benefits will apply. • The diagnosis and procedure codes submitted by the Provider determine whether a service is considered a Preventive Care Service. • Preventive Care Services are subject to treatment, setting, frequency, and medical management criteria, which must be satisfied in order for the service or supply to be covered by the Plan at 100%. Lab tests and other services ordered by a Health Care Provider may not meet the criteria to be covered as Preventive Care Services and, therefore, may be subject to the applicable Deductible, Copay, and/or Coinsurance. • If an ACA Preventive Care Service recommendation or guideline does not specify the frequency, method, treatment, or setting for the provision of that service, the Plan will use reasonable medical management techniques (such as age, frequency, location, method) to determine coverage parameters.	**For information about the Preventive Care Services immunizations, screenings, and other services and supplies that are covered by the Fund at 100% when you use a PPO Provider, please contact the Fund Office for a copy of the official Preventive Care Guidelines or see www.ufcwdrugtrust.org/.** These guidelines are updated on an annual basis and have been put into a "member friendly" format. **When you use a PPO Provider**, Preventive Care Services that are required to be covered under the ACA will be payable at 100% with no Deductible, as described in the Fund's official Preventive Care Guidelines. **When you use a Non-PPO Provider**, most Preventive Care Services are covered at 50% of the Allowed Amount after the Deductible, but some services are not covered Out-of-Network. If there is no PPO Provider who can provide the Preventive Care Service, then the Fund will cover the service when performed by a Non-PPO Provider without Cost Sharing. **Please note:** For full benefits, you must use a PPO Provider if one is available in your geographic area. See the "Generic Preventive Care Drugs (including FDA-approved contraceptives)" row in the Schedule of Prescription Drug Benefits (in the "Prescription Drug Program" Chapter) for information on coverage for certain Preventive Care Services drugs in compliance with the ACA.

V
PRESCRIPTION DRUG PROGRAM

In this Chapter, the terms "you" and "your" refer to the Participant, which includes both Employees and Dependents.

Please note that the Prescription Drug Program described in this Chapter applies to ALL Participants, whether enrolled in the Indemnity Medical Plan, the Kaiser Permanente HMO Plan, or the UnitedHealthcare HMO Plan.

The Fund has contracted with Optum Rx to administer its Prescription Drug Program. **You MUST fill your prescriptions at a Participating Pharmacy, otherwise there is no coverage available**, unless an exception applies.

Visit www.optumrx.com to create your secure account (called My Medicine Cabinet) and find information about your coverage under the Prescription Drug Program. You'll need to have your Optum Rx ID card handy – as you will need the Rx ID number from the card to create an account.

1. Participating Pharmacies

Participating Pharmacies are listed in the So. CA Drug Fund Participating Pharmacy Directory (referred to as the "Participating Pharmacy Directory"). **If you attempt to fill a prescription at a pharmacy that is not a Participating Pharmacy, the prescription will not be covered by the Fund**, unless an exception applies. *See Section 2 ("Exceptions to the Requirement to Use a Participating Pharmacy") of this Chapter, below, for more information.*

The following pharmacies (and pharmacies in the following chain stores) are Participating Pharmacies listed in the Participating Pharmacy Directory:

- Rite Aid
- Certain CVS pharmacies **
- Vons
- Ralphs
- Albertsons
- Pavilions
- Gelson's Markets
- Safeway
- Food-4-Less
- Raley's (Northern California)
- Bel Air (Northern California)

***Many, but not all, CVS Pharmacies are Participating Pharmacies.*

For a complete list of all Participating Pharmacies, including certain CVS Pharmacies, contact the Fund Office. You may also view the Participating Pharmacy Directory on the Fund's website at www.ufcwdrugtrust.org (click the "Documents & Forms" tab from the menu, and then click on the "Medical/Prescription" tab underneath the "Documents" header).

The Participating Pharmacy Directory is updated regularly. If you are unsure of whether a particular pharmacy is a Participating Pharmacy, you may consult the Directory (at www.ufcwdrugtrust.org) or call the Fund Office.

2. Exceptions to the Requirement to Use a Participating Pharmacy

You do not have to use a Participating Pharmacy for the following:

- **Specialty Drugs and other drugs not available at retail**. In this case, you or your Provider must contact Optum Rx for instructions on how to fill your prescription (for Specialty Drugs you will generally use an Optum Rx Specialty Pharmacy).
- **Compound Drugs**. You may use any Compounding Prescription Pharmacy. You will pay the full cost of the prescription up front then submit a Prescription Reimbursement Claim form with the itemized receipt to the Fund Office for reimbursement. It is recommended that you take the Prescription Reimbursement Claim form to the Compounding Pharmacy for assistance in completing the form.
- **One Time Exceptions.** The Fund will process a one-time exception to the requirement to use a Participating Pharmacy in certain limited circumstances. Please contact the Fund Office for more information or assistance. To apply for this exception, you will need to submit the following to the Fund Office: (i) a completed Prescription Drug Claim Form (available from the Fund Office); (ii) an itemized receipt for the purchase of the drug; (iii) the label from the Prescription Drug (showing date filled, purchase price, NDC #, and name of the medication); and (iv) a written explanation detailing why the drug was not purchased at a Participating Pharmacy. If a one-time exception applies, you will be reimbursed Optum Rx's allowed expense for the drug minus the applicable Copayment (or Coinsurance, if applicable). Charges above Optum Rx's allowed expense are not subject to the Prescription Drug Out-of-Pocket maximum.

3. Lower-Cost Drugs

Brand Name Drugs can often be more expensive than Generic Drugs. Generic Drugs have the same active ingredients, are approved by the U.S. Food and Drug Administration, and have the same quality and effectiveness as Brand Name Drugs. Further, multiple drugs might exist to treat the same condition—all with varying costs.

Generally, the Fund will not cover a more expensive drug (such as a Brand Name Drug) if a lower-cost option that is just as effective for your treatment (such as a Generic Drug) is available. If your doctor believes that a higher-cost drug is medically necessary for your care, he or she can apply for an exception on your behalf by contacting Optum Rx.

4. Preauthorization Requirements

Certain Prescription Drugs require Preauthorization from Optum Rx in order to be covered by the Fund.

When Preauthorization is required, Optum Rx will ordinarily communicate with your prescribing Physician or Provider to assess Medical Necessity and assure appropriate utilization of the prescribed

drugs. These Prescription Drugs will not be covered unless Preauthorization requirements are met.

Prescription Drugs that require Preauthorization include, but are not limited to, the following:

- ✓ **Specialty Drugs** – All Specialty Drugs on Optum Rx's Standard Specialty Drug list
- ✓ **Certain self-injectable drugs**
- ✓ **Compound Drugs** costing $150 or more
- ✓ **Certain opioids, diabetes medications, and weight-loss drugs** – Coverage for these drugs may not be available unless you have first tried lower-risk options (a practice called step therapy).

To find out whether a particular drug requires Preauthorization, contact the Fund Office or Optum Rx. Your doctor may also contact Optum Rx.

If Preauthorization is initially denied by Optum Rx, your doctor may participate in a peer-to-peer review with Optum Rx to request that Preauthorization be approved. The peer-to-peer review involves your doctor talking through the decision with another Provider. To arrange a peer-to-peer review with Optum Rx, your prescribing doctor should call Optum Rx at the number on your Prescription ID card.

5. Quantity Limits

Some Prescription Drugs are subject to quantity limits. If a quantity limit applies, the Fund will not cover more than the applicable quantity limit. To determine if a quantity limit applies to a specific drug, please contact Optum Rx.

6. 30-Day Supply and 90-Day Supply for Certain Maintenance Drugs

The Fund generally provides benefits for up to a 30-day supply of drugs to treat an acute condition. For maintenance drugs in certain therapeutic classifications (see below), a 90-day supply may be obtained.

90-Day Supply for Certain Maintenance Drugs for Select Conditions at Lower Copay

Maintenance drugs are those drugs that are approved for long-term therapy. For certain maintenance drugs on the Fund's maintenance medication list, you can obtain a 90-day supply for the same copay that you would pay for a 30-day supply.

To determine if a particular drug is on the Fund's maintenance medication list, please contact the Fund Office.

If You Will be Outside of the United States for an Extended Period of Time

If you will be outside of the United States for an extended period of time, and you need more than a 30-day supply (or 90-day supply for certain maintenance medications) of your prescription drug(s), you may contact the Fund Office to request a vacation override. You must comply with the Fund's requirements to obtain such an override.

7. Copayments

A Copayment is a fixed dollar amount that you are responsible for paying when you purchase a covered Prescription Drug from a Participating Pharmacy. These amounts are detailed in the Schedule of Prescription Drug Benefits below (see Section 12 of this Chapter).

8. Diabetes Management Program

If you have diabetes and are at higher risk, you may be eligible to participate in Optum Rx's Diabetes Management Program. This program provides tailored individual guidance and coaching with a pharmacist to help you manage your condition. In addition, you may be provided with a free blood glucose meter and testing strips or a continuous glucose monitor if you participate in the program.

9. Coordination of Prescription Drug Benefits

If you or any of your Dependents have coverage under another employer's plan through your Spouse/Domestic Partner or through other employment, you can use the Prescription Drug Program to cover up to the full cost of a prescription.

Coordination of prescription drug benefits cannot occur at the time of the purchase. To coordinate benefits, you must file a claim for reimbursement with the Fund Office. Here is how this coordination works:

1. File a claim first with your other medical plan.

2. After you fill your prescription through the other plan, submit the following to the Fund Office:

   (i) a completed Prescription Drug Claim Form (available from the Fund Office); (ii) an itemized receipt for the purchase of the drug; and (iii) the label from the Prescription Drug (showing date filled, purchase price, NDC #, and name of the medication).

3. The Fund will then reimburse you for the copayment you have paid for your prescription plus $1.00 (Participants with Dual Coverage under the Fund will not receive the $1.00 but will be reimbursed their Copays).

10. If You Live outside of California

Participants who do not live in California may obtain their Prescription Drugs through a Participating Pharmacy or by using Optum Rx's mail order service.

11. Out-of-Pocket Maximum for Covered Prescription Drugs

Each calendar year, after an individual or family has incurred a specified amount of out-of-pocket expenses for drugs covered under the Prescription Drug Program and obtained from Participating Pharmacies or from an Optum Rx Specialty Pharmacy (for specialty drugs not available through retail), no further Copays or Coinsurance will be required for most covered Prescription Drugs. As a result, if the Prescription Drug Out-of-Pocket Maximum ("Rx OOP Max") is reached, the Fund will pay 100% of the cost of most of your covered Prescription Drugs (except for the out-of-pocket expenses you always pay, which are listed below) for the remainder of the calendar year.

Please note there is a separate medical Out-of-Pocket Maximum that applies to PPO medical expenses. *See Section 9 of the Chapter of this booklet entitled "The Indemnity Medical Plan" for more information.*

This Rx OOP Max applies to drugs covered under the Prescription Drug Program. However, in the event you fill a prescription through a non-Participating Pharmacy and a one-time exception applies, the Rx OOP Max does not apply to charges that exceed Optum Rx's allowed expense for the drug.

Expenses you always pay and that do not accumulate towards the Rx OOP Max. The following expenses do not count towards the Prescription Drug Out-of-Pocket Maximum and will not be covered at 100% once you reach your Rx OOP Max:

- Drugs that are not covered under the Prescription Drug Program, including drugs covered under the Indemnity Medical Plan or one of the Fund's HMO Plans, such as injectable drugs supplied and administered by a Physician (such drugs are generally subject to the medical Out-of-Pocket Maximum).

- Drugs not purchased at a Participating Pharmacy, an Optum Rx Specialty Pharmacy, or the Optum Rx Mail Order program (for Participants living outside of California), unless a one-time exception applies. If a one-time exception applies, any expenses you pay above Optum Rx's allowed expense for the drug do not count towards the Rx OOP Max and will not be paid by the Fund in the event the Rx OOP Max is reached.

The Schedule of Prescription Drug Benefits below (see Section 12 of this Chapter) outlines the Prescription Drug Out-of-Pocket Maximum and any amounts (Copays and/or Coinsurance) that you will be responsible for when you obtain a Prescription Drug.

12. Schedule of Prescription Drug Benefits

See next page.

SCHEDULE OF PRESCRIPTION DRUG BENEFITS

This chart explains your Cost Sharing under the Prescription Drug Program. See also the "Excluded Services and Limitations" and "Definitions" Chapters of this booklet for important information.

IMPORTANT: Prescription Drugs obtained from Non-Participating Pharmacies are generally not covered.

	Gold Plan	Platinum Plan
Prescription Drug Out-of-Pocket Maximum	**Indemnity Medical Plan Enrollees:** For the 2025 calendar year, $6,950 individual/$11,900 family per year for prescriptions filled at Participating Pharmacies. **Kaiser/UHC HMO Enrollees:** For the 2025 calendar year, $7,450 individual/$14,900 family per year for prescriptions filled at Participating Pharmacies *The Prescription Drug Out-of-Pocket Maximum changes annually. Please review your SBC or annual open enrollment materials for information about the current maximum.*	
Maximum Days Supply	• Maximum 30-day supply per prescription. • For maintenance drugs in certain therapeutic classifications, a 90-day supply may be obtained.	
Generic Preventive Care Drugs (including FDA-approved contraceptives)	Plan pays 100% for certain preventive care drugs as required under the ACA. A prescription is required or there is no coverage. Please refer to the Indemnity Medical Plan Preventive Care Guidelines for the most up-to-date description of what is covered (www.ufcwdrugtrust.org). Brand Name Drugs will be covered when a generic is unavailable or medically inappropriate, but the Brand Name Drug must be authorized by Optum Rx. Age and frequency limits apply.	
Generic	$12 Copay per prescription.	$8 Copay per prescription.
	No charge for FDA-approved generic contraceptives (or Brand Name if a generic is medically inappropriate, but must be authorized by Optum Rx).	
Formulary Brand	$30 Copay per prescription	$25 Copay per prescription
	These Copays are applicable only when no generic equivalent is available or if your doctor indicates "dispense as written." If a generic equivalent is available and your doctor does not indicate "dispense as written," you must pay the cost difference between the Generic Drug and the Brand Name Drug plus the applicable Copay ($25 or $30).	
Non-Formulary Brand	$50 Copay per prescription	$45 Copay per prescription.
Self-Injectables	The Fund pays 80% of Optum Rx's Contract Rate. **Certain self-injectables require Preauthorization through Optum Rx.** **For UHC HMO enrollees:** Self-injectables that are prescribed by UHC Physicians and provided by UHC are covered at 100% by the UHC HMO Plan and are not covered by the Prescription Drug Program.	
Compound Drugs	The Fund pays 80% of the retail cost. **Preauthorization through Optum Rx is required.** For compounded drugs, you must pay for the prescription up front, then submit a Claim for reimbursement to the Fund Office.	

13. Special Rule for HMO Participants regarding Injectable Medications

In most cases, if you are enrolled in an HMO Plan and are taking a medication that is administered by injection, the medication will be covered by your HMO. If an injectable drug (other than insulin) is not covered by your HMO, you may submit a request for reimbursement to the Fund Office and have it covered under the Fund's Prescription Drug Program at 80% of Optum Rx's Contract Rate. Contact the Fund Office for help on how to submit a request for reimbursement.

14. Prescription Drug Limitations

A. **Growth Hormone** – For cases meeting the Preauthorization requirements, reimbursement will be 80% of the Allowed Charge, less the applicable Copayment. No coverage unless preauthorized by Optum Rx.

B. **Pulmozyme (Dornase Alfa)** Recombinant Inhalant Solution – Covered at 68% of the Allowed Charge, less the applicable Copayment.

15. Prescription Drug Exclusions

Certain services, supplies, or expenses are **not covered (meaning they are excluded) by the Plan**. In addition to the exclusions in the "Excluded Services and Limitations" Chapter of this booklet, the Prescription Drug Program does not pay for the following:

A. Drugs and items that are not Medically Necessary for the treatment of an Illness or Injury, except as specifically covered, such as oral contraceptives and other medications covered as Preventive Care Services.

B. Prescriptions dispensed by a Hospital during confinement (such drugs may be covered by your medical plan, i.e., the Indemnity Medical Plan or your HMO Plan).

C. Drugs dispensed by the Hospital pharmacy as a "take-home" medication.

D. Drugs, medications, or non-drug items that may be purchased without a Healthcare Provider's written prescription (includes drugs which bear an Rx legend, but have the same ingredients as an over-the-counter drug), except that diabetic supplies and certain over-the-counter drugs covered as Preventive Care Services are covered.

E. Contraceptive devices (these may be covered under the Indemnity Medical Plan or your HMO Plan) and over-the-counter contraceptive drugs or methods, except for the drugs and methods covered as Preventive Care Services. *For information about coverage of contraceptive drugs, see the "Generic Preventive Care Drugs (including FDA-approved contraceptives)" row of the Schedule of Prescription Drug Benefits in this Chapter. If you are enrolled in an HMO Plan, refer to your Evidence of Coverage (EOC) for coverage information pertaining to contraceptive devices or call the Fund Office.*

F. Immunization agents (these may be covered under the Indemnity Medical Plan), except that certain immunizations received at Participating Pharmacies are covered under the Prescription Drug Program. If you are enrolled in an HMO Plan, refer to your Evidence of Coverage (EOC) for coverage information or call the Fund Office.

G. Injectable drugs administered or dispensed by a Physician, nurse, or other Healthcare Provider, or while inpatient in a Hospital or Healthcare Facility (these may be covered under the Indemnity Medical Plan or your HMO Plan).

H. Drugs dispensed directly by a doctor or in a doctor's office.

I. Appliances or prosthetics and other non-drug items. *For coverage information, see Section 16 ("Schedule of Medical Benefits") of the Chapter of this booklet entitled "The Indemnity Medical Plan."*

J. Workers' Compensation prescriptions.

K. Drugs used for the treatment of infertility.

L. Drugs used to promote hair growth.

M. Non-FDA approved drugs or FDA-approved drugs being used for treatments that are not FDA-approved.

N. Drugs dispensed in greater quantities than approved by the FDA.

O. Lost, stolen, broken, or spilled drugs or supplies.

P. Services or medications otherwise covered under the Indemnity Medical Plan.

Q. Tobacco cessation products or medications (except as covered under the Fund's Preventive Care Guidelines).

R. Compound drugs without at least one federal legend ingredient (i.e., Compound Drugs with only over-the-counter ingredients are not covered).

VI
EXCLUDED SERVICES AND LIMITATIONS

1. General Exclusions and Limitations

The Fund does not pay benefits for the following:

1. Expenses for a non-covered service, supply, treatment, procedure, or drug.

2. Missed appointment fees, late payment fees, interest charges, financial penalties (such as amounts owed to Providers due to the 60% benefit reduction under the Working Spouse Rule), and other similar non-health care expenses.

3. Charges incurred while the Participant's coverage is not in effect (i.e., while the Participant is not eligible for Fund coverage).

4. Services and supplies for which no charge is made, or for which one is not required to pay.

5. Charges in excess of Contract Rates or the Allowed Amount, as applicable.

6. Services or supplies that are not Medically Necessary, unless expressly covered under the Fund.

7. Experimental or Investigational services, supplies, treatments, procedures, drugs, and therapies, and any complications arising therefrom. This exclusion does not apply to routine costs related to participation in an approved clinical trial, as required under the federal Affordable Care Act.

8. Services provided by an immediate relative of an eligible Participant or by a member of a Participant's household, except for Covered Expenses that are Out-of- Pocket expenses to the Providers. The term "immediate relative" means Spouse or Domestic Partner, Child, parent, sibling, parent of current Spouse or Domestic Partner, or grandparent.

9. Claims filed more than one year after the date on which services were incurred.

10. Injuries resulting from any form of warfare or invasion.

11. Any services or supplies furnished by a Hospital or facility operated by the U.S. Government or any authorized agency thereof, or furnished at the expense of such Government or agency, except as required by federal law. This exclusion does not apply to services or supplies furnished by a department or agency of the United States, including a Veterans Hospital, to treat a non-service-connected disability or injury.

12. Conditions covered by Workers' Compensation or arising out of or incurred in the course of employment, including self-employment. *See the "Workers' Compensation & Third Party Liability" Chapter of this booklet for more information.*

13. Expenses for services or supplies for which a third party is required to pay because of the negligence or other tortious or wrongful act of that third party. *See the "Workers' Compensation & Third Party Liability" Chapter of this booklet for more information.*

14. Educational Services. Even if they result from an Injury, Illness, or disability of a Participant, the

following expenses are not payable by the Fund: (a) educational services, supplies or equipment, including, but not limited to, computers, computer devices, software, printers, books, tutoring or interpreters, visual aids, auditory or speech aids, synthesizers, auxiliary aids, communication boards, or listening systems; (b) devices, programs, or services for behavioral training including intensive intervention programs for behavior change, developmental delays, or auditory perception and/or listening/learning skills, except that otherwise covered Medically Necessary services related to the treatment of a mental health condition covered under this Plan, including applied behavior analysis, are payable under the Plan's terms; (c) programs and services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc.; (d) special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members; and (e) implantable medical identification/tracking devices.

15. Orthodontic care.

16. Services or supplies that exceed any applicable dollar or visit limit.

2. Indemnity Medical Plan Exclusions and Limitations

In addition to the "General Exclusions and Limitations" listed in Section 1 of this Chapter, above, the Indemnity Medical Plan (the "Plan") does not pay for the following:

1. Services or supplies that are not Medically Necessary for the treatment of an Illness or Injury, unless specifically covered under the Plan, such as Preventive Care Services.

2. Expenses incurred for any condition where there exists no Injury or Illness, except that this exclusion does not apply to benefits specifically provided, such as hospice care, sterilization procedures, and Preventive Care Services.

3. Any services or supplies not prescribed, ordered, recommended, or approved by a Physician or other Health Care Provider performing services within the legal scope of their practices.

4. Cosmetic Surgery or treatment and complications resulting from any such procedure, except to repair damage caused by accidental bodily Injury or as otherwise expressly covered, such as breast reconstruction following a mastectomy.

5. Organ or tissue transplants performed at a facility that is not an Anthem Center of Medical Excellence.

6. Organ or tissue transplants, unless the transplant recipient is a Plan Participant.

7. Expenses incurred by an organ or tissue donor who is not a Plan Participant (except for benefits specifically provided).

8. Any expenses incurred by an organ or tissue donor, unless the transplant recipient is a Plan Participant.

9. Donor search, organ or tissue procurement, and donor expenses, except as specifically covered/provided.

10. Pregnancy (including maternity and delivery) expenses of Children and expenses for conditions arising from pregnancy of Children, except Preventive Care Services and Emergency Services as mandated by law.

11. Take home drugs when discharged from the Hospital.

12. Personal items provided in a Hospital.

13. Ambulance or other transportation services primarily to suit the patient's or Provider's convenience.

14. Paramedic services when the patient is not transported to a Hospital.

15. Out-of-Network telehealth visits.

16. Rental charges for Durable Medical Equipment, medical supplies, and Orthopedic Appliances that exceed the reasonable purchase price of the equipment.

17. Repairs of artificial limbs or Orthopedic Appliances during the 12-month period following the date of purchase.

18. Equipment for exercise, environmental control, or primarily for the patient's comfort or hygiene.

19. Any expenses connected with any form of artificial insemination, non-surgical treatment for infertility after diagnosis, or the reversal of voluntary infertility, or any expenses connected with or resulting from sperm banks.

20. Any expenses connected with or resulting from surrogate pregnancies, whether the surrogacy is for a Plan Participant or the Plan Participant is the surrogate. This exclusion does not apply to certain Preventive Care Services screenings for a pregnant Plan Participant.

21. Custodial care (regardless of the type of facility and/or Provider) and homemaker services.

22. Podiatric care received from an Out-of-Network podiatrist, except for the special podiatry benefit. In addition, benefits for podiatric care are limited to those specifically described.

23. Tobacco cessation programs (except when covered as Preventive Care Services).

24. Weight loss programs (except when covered as Preventive Care Services).

25. Physical fitness programs or club memberships.

26. Vocational testing, evaluation, and counseling.

27. Penile prosthesis unless Preauthorized by Anthem Blue Cross.

28. Replacement of artificial eyes.

29. Eye examinations including refractions and fitting of glasses, hearing aids, health aids, artificial limbs, and Orthopedic Appliances, except as specifically covered.

30. Surgical correction of refractive eye problems, including radial keratotomy, unless vision cannot be corrected through eyeglasses or contact lenses.

31. Speech therapy, unless from a PPO Provider.

32. Orthognathic (i.e., jaw correction) surgery.

33. Treatment on or to teeth or gums and dental x-rays, except for tumors. *Dental care is covered under the Indemnity Dental Plan or the United Concordia Dental HMO Plan.*

34. Any health care services and/or supplies that a Plan Participant receives pursuant to a Medicare Private Contract if this Plan is secondary to Medicare.

35. Drugs covered under the Prescription Drug Program.

3. Prescription Drug Program Exclusions and Limitations

In addition to the services and supplies listed in Section 1 ("General Exclusions and Limitations") of this Chapter, above, the Prescription Drug Program does not pay for the services and supplies listed in Section 14 ("Prescription Drug Limitations") and Section 15 ("Prescription Drug Exclusions") of the "Prescription Drug Program" Chapter of this booklet.

4. Indemnity Dental Plan Exclusions and Limitations

In addition to the services and supplies listed in Section 1 ("General Exclusions and Limitations") of this Chapter, above, the Indemnity Dental Plan does not pay for services and supplies that are excluded from coverage or are not a covered benefit under the Indemnity Dental Plan, as listed in the Fund's current Southern California Drug Benefit Fund Indemnity Dental Schedule of Allowances for the Gold and Platinum Plans (referred to as the "Dental Schedule of Allowances") and the Delta Dental Combined Evidence of Coverage and Disclosure Form for the Southern California Drug Benefit Fund, available on the Fund's website or by calling the Fund Office.

VII
THE HMO PLANS

In this Chapter, the terms "you" and "your" refer to the Participant, which includes both Employees and Dependents.

This Chapter provides a brief description of the Kaiser Permanente HMO Plan and the UnitedHealthcare HMO Plan. For a full explanation of the benefits provided under these HMO Plans, please refer to the HMO's official Evidence of Coverage (EOC) issued by Kaiser or UHC. ***If there is a conflict between any description of HMO benefits in this booklet and the HMO Plan's EOC or the Fund's contract with the HMO, the EOC and the contract with the HMO will control.*** *Please call the HMO at the telephone number listed in the Quick Reference Chart for a copy of the EOC.*

The Fund offers a choice between two HMO Plans, as alternatives to the Indemnity Medical Plan. **Generally, you may elect coverage under one of the Fund's HMO Plans beginning with the fourth annual open enrollment after your most recent date of hire.** For exceptions to this rule, see Section 1.A ("Choice of Medical Plans") of the "Choice of Health Plans" Chapter of this booklet.

The two HMO Plan options offered by the Fund are:

- The Kaiser Permanente HMO Plan ("Kaiser HMO")
- The UnitedHealthcare HMO Plan ("UHC HMO")

To enroll in one of the Fund's HMO Plans, you must live within the plan's service area, generally within 30 miles of a medical facility of the HMO Plan.

Note: Certain disputes which may arise between a Participant enrolled in an HMO Plan and the HMO Plan are subject to binding arbitration. Both Kaiser and UHC require binding arbitration of claims for medical malpractice. By enrolling in one of the Fund's HMO Plans, you are giving up your right to a jury or court trial to resolve any dispute which is subject to binding arbitration. See the HMO Plan's enrollment packet for more details.

If you choose an HMO Plan, Indemnity Medical Plan benefits are not available to you, except for certain ancillary benefits described in Section 4 of this Chapter, below, and in the "Ancillary Fund Benefits" Chapter of this booklet.

1. The Kaiser Permanente HMO Plan

Here is a quick overview of how the Kaiser HMO Plan works:

- Under the Kaiser HMO, you are required to use Kaiser Providers for your care. In general, no benefits are payable for services provided outside the Kaiser HMO network, except for Emergency Services.
- Generally, you pay a copayment for each office visit. Preventive care is covered at 100%.
- For Hospital stays and outpatient surgeries, once you have satisfied the deductible, Kaiser will generally pay 80% of Covered Charges; you are responsible for the remaining 20% as coinsurance. Specific copays, coinsurance, and deductible amounts are outlined in the Summary of the Platinum and Gold Plans, available from the Fund Office and on the Fund's website.

- Once your out-of-pocket expenses reach the annual out-of-pocket maximum ("OOP Max"), your medical care will generally be covered in full for the remainder of the calendar year. You must keep records (receipts) of your copays and coinsurance to provide as proof to Kaiser that you have reached your OOP Max.

    ⇒ The OOP Max generally applies to medical care and mental health and substance use disorder services provided by Kaiser Providers.

    ⇒ The following expenses don't count towards the OOP Max and will not be paid or reimbursed by Kaiser at 100% in the event you reach your OOP Max: employee premiums, non-covered expenses, charges in excess of a benefit maximum, and expenses you pay for ancillary benefits provided through the Fund (as described in Section 4 of this Chapter, below), prescription drugs, and dental care.

- When you enroll in the Kaiser HMO, all medical benefits received by you and your Dependents will be provided through the Kaiser HMO, except for the following:

    ⇒ ***Prescription Drug Benefits.*** Coverage is provided through the Prescription Drug Program administered by Optum Rx. *For more information, see the "Prescription Drug Program" Chapter of this booklet.*

    ⇒ ***Ancillary Benefits.*** The Fund provides certain benefits that may not be available from your HMO Plan. *For more information, see Section 4 of this Chapter, below, and the "Ancillary Fund Benefits" Chapter of this booklet.*

    ⇒ ***Dental Benefits.*** The Fund provides dental benefits under a separate Dental Plan. *For more information, see the "Dental Benefits" Chapter of this booklet.*

- For a more complete description of the benefits available under the Kaiser HMO, please see the current Summary of the Platinum and Gold Plans, available from the Fund Office and on the Fund's website. Alternatively, you may call Kaiser Customer Service and request a copy of the EOC for your Kaiser HMO Plan.

2. The UnitedHealthcare HMO Plan

Here is a quick overview of how the UHC HMO Plan works:

- The UHC HMO Plan offers a choice of three networks of Providers – Harmony, Alliance, and SignatureValue (SV). You must choose one network, and all of your family members must be enrolled in the same network. You and your family members will have access only to Providers in the network you choose.

- Each family member may individually select a primary care physician ("PCP") within the chosen network. If you do not choose a PCP, UHC will designate one for you. You may only change your network during Open Enrollment (unless you or a Dependent has a Special Enrollment Right).

- The amount you pay for services depends on the Provider network you choose. If you live in the service area of either the Harmony or the Alliance network, you will have the lowest out-of-pocket costs when you choose a PCP in the Harmony or Alliance network. If you live in the Harmony or Alliance service area, and you choose a PCP from the SV network, you will have higher Copayments and Coinsurance.

- If you do not live within the service area of the Harmony or the Alliance network, you will participate and choose a PCP from the SV network, and your benefits will be the same as those under the Harmony and Alliance networks.

- You must use Providers in your chosen network. Services furnished by a Provider who is not in your chosen network are not covered, with the following exception: claims subject to the No Surprises Act ("NSA Claims") (i.e., claims for out-of-network Emergency Services, including air ambulance, and certain non-emergency services furnished by out-of-network Providers at in-network health facilities) are treated as though furnished by in-network Providers, in accordance with the federal No Surprises Act.

- Specific copays, coinsurance, and deductible amounts are outlined in the Summary of the Platinum and Gold Plans, available from the Fund Office and on the Fund's website.

- When you enroll in the UHC HMO Plan, all medical benefits received by you and your Dependents will be provided through the HMO, except for the following:

  ⇒ ***Prescription Drug Benefits.*** Coverage is provided through the Prescription Drug Program administered by Optum Rx. *For more information, see the "Prescription Drug Program" Chapter of this booklet.*

  ⇒ ***Ancillary Benefits*.** The Fund provides certain benefits that may not be available from your HMO plan. *For more information, see Section 4 of this Chapter, below, and the "Ancillary Fund Benefits" Chapter of this booklet*.

  ⇒ ***Dental Benefits*.** The Fund provides dental benefits under a separate Dental Plan. *For more information, see the "Dental Benefits" Chapter of this booklet.*

3. Patient Protections

A. Kaiser HMO Enrollees

Personal plan physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists. Kaiser Permanente encourages you to choose a personal plan physician. You may choose any available personal plan physician. Parents may choose a pediatrician as the personal plan physician for their child.

To learn how to select a personal plan physician, please refer to Your Guidebook or call Kaiser's Member Service Call Center. You can find a directory of plan physicians on Kaiser's website at kp.org. For the current list of physicians that are available as primary care physicians, please call the personal physician selection department at the phone number listed in Your Guidebook. You can change your personal plan physician for any reason.

You do not need a referral or prior authorization from any person (including a personal plan physician) to obtain access to obstetrical or gynecological care from a health care professional who specializes in obstetrics or gynecology. Please see your Evidence of Coverage for more information.

B. UnitedHealthcare HMO Enrollees

UHC generally requires the designation of a primary care provider. You have the right to designate any primary care provider who participates in the Network you selected (i.e., the Harmony, Alliance, or

SV Network) and who is available to accept you or your family members. Until you make this designation, UHC designates one for you. For information on how to select a primary care provider, and for a list of the participating primary care providers, contact UHC at (800) 624-8822 or visit www.myuhc.com. For children, you may designate a pediatrician, within the Network you have selected, as the primary care provider.

You do not need prior authorization or a referral from UHC or from any other person (including a primary care provider) in order to obtain access to obstetrical or gynecological care from a health care professional within your Medical Group who specializes in obstetrics or gynecology. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your Medical Group or UHC at (800) 624-8822.

4. Ancillary Fund Benefits Available to HMO Enrollees

If you are enrolled in one of the Fund's HMO Plans, most of your medical care will be provided through your HMO. However, as explained in Section 1 (for Kaiser) and Section 2 (for UHC) of this Chapter, above, Prescription Drug benefits are provided by Optum Rx through the Fund's Prescription Drug Program.

In addition, the Fund provides the following ancillary benefits to all Participants, including HMO Plan enrollees: vision benefits, hearing aids, the special podiatry benefit, temporo-mandibular joint (TMJ) benefits, and artificial limbs and Orthopedic Appliances. *For more information, see the Chapter of this booklet entitled "Ancillary Fund Benefits."*

VIII
ANCILLARY FUND BENEFITS

In this Chapter, the terms "you" and "your" refer to the Participant, which includes both Employees and Dependents.

The Fund provides the ancillary benefits listed below to all Participants, regardless of whether you are enrolled in the Indemnity Medical Plan, the Kaiser HMO, or the UHC HMO.

If you do not assign your Fund benefits (i.e., payment) to your Provider, the Fund payment for these benefits will be made directly to you. You may obtain Claim forms for these benefits from the Fund Office or your Local Union Insurance Office.

1. Vision Benefits

The Fund provides the following benefits for routine eye exams, frames, and lenses (including contact lenses), regardless of whether you use PPO or Non-PPO Providers:

- **Pediatric Vision Care (up to age 19):** Routine eye exams are covered at 100%, up to $135 per exam. Amounts paid for routine eye exams will reduce the annual $135 maximum benefit for frame and lenses.

- **Adult Vision Care (age 19 and older):** Routine eye exams and frames/lenses are covered at 100% up to $135 per calendar year, for exam and materials combined.

Unused vision benefits from the previous calendar year are automatically rolled over for use in the current calendar year, but no more than $135 from a prior year can be rolled into any calendar year.

For vision benefits to be provided, you must submit a completed Vision Claim Form to the Fund Office, along with an itemized bill, a valid prescription for frames and/or materials, and a copy of the receipt(s). Payment for prescription lenses will be made only if a valid prescription is presented to the Fund as part of your Claim.

For HMO enrollees: This benefit is in addition to vision services that may be available through your HMO Plan (the Kaiser HMO and the UHC HMO both cover routine eye exams at 100%).

Note: You are permitted to opt-out of vision coverage for yourself and your Dependents. However, opting out of vision benefits will not change the amount of your Employee Contribution/Premiums.

This benefit is also described in the "Vision Services" row of the Schedule of Benefits of the Indemnity Medical Plan, at Section 16 of "The Indemnity Medical Plan" Chapter of this booklet.

2. Hearing Aids

For patients whose Physician has certified a hearing loss that may be lessened by the use of a hearing aid, the Fund pays 80% of the Allowed Amount for the Physician examination and the external hearing aid, up to a maximum of $750 for each ear, not more often than once during any 12-month period.

The hearing aid benefit is NOT provided under the following circumstances:

(1) The Physician's exam is made without an instrument being purchased.

(2) Replacement of instruments for any reason more often than once during any 12-month period.

(3) Reimbursement for batteries or ancillary equipment, unless obtained with the initial purchase of the equipment.

(4) Reimbursement for repairs, servicing, or alteration of the hearing aid.

This benefit is also described in the "Hearing Aids" row of the Schedule of Medical Benefits for the Indemnity Medical Plan, at Section 16 of "The Indemnity Medical Plan" Chapter of this booklet.

3. Special Podiatry Benefit

A separate $120 per calendar year benefit is available for office calls and charges (including x-rays) by Non-PPO Providers incurred for the non-surgical treatment of chronic foot conditions, such as weak or fallen arches, flat or pronated feet, hallux valgus, metatarsalgia, or foot strain, and toenail trimming and surgical treatment involving debridement of painful clavi.

This benefit is also described in the "Podiatry Services" row of the Schedule of Medical Benefits for the Indemnity Medical Plan, at Section 16 of "The Indemnity Medical Plan" Chapter of this booklet.

4. Temporo-Mandibular Joint (TMJ) Benefit

If the Fund or its Dental Consultant Preauthorizes treatment as Medically Necessary: (1) a lifetime maximum of $2,000 will be allowed for the surgical correction of a temporo-mandibular joint (TMJ) problem by an oral surgeon; and (2) up to $500 will be paid for the non-surgical treatment of TMJ problems within any 12-month period (and amounts paid for the non-surgical treatment of a TMJ problem will reduce the $2,000 available for a later surgical correction).

This benefit is available whether you are covered under the Indemnity Dental Plan or the United Concordia Dental HMO Plan.

This benefit is also described in the "TMJ Services" row of the Schedule of Medical Benefits for the Indemnity Medical Plan, at Section 16 of the "The Indemnity Medical Plan" Chapter of this booklet.

5. Artificial Limbs and Orthopedic Appliances

The Fund provides coverage for Medically Necessary artificial limbs and Orthopedic Appliances as follows:

- **Artificial Limbs:** The Fund pays 100% of Contract Rates for PPO Providers (100% of the Allowed Amount for Non-PPO Providers) after the Deductible for the purchase or repair of artificial limbs, but not during the 12-month period following the date of purchase.

- **Orthopedic Appliances:** The Fund pays 100% of Contract Rates for PPO Providers (100% of the Allowed Amount for Non-PPO Providers), not subject to the Deductible, for the purchase or rental of Orthopedic Appliances and replacements up to once a year (or more if Medically Necessary). A Physician's prescription is required.

Exclusions and Limitations:

(1) Rental charges that exceed the reasonable purchase price of the equipment are not covered.

(2) Support stockings, elastic stockings, crutches, walking canes, and trusses are not covered as Orthopedic Appliances (and are not paid at 100%).

(3) Repairs of artificial limbs or Orthopedic Appliances during the 12-month period following the date of purchase are not covered.

(4) Orthopedic Appliances limited to purchase or rental up to once every calendar year.

(5) If a Participant's coverage under the Fund is terminated, and an artificial limb or Orthopedic Appliance is required as a result of a disability which was incurred while the patient had coverage under the Fund, this benefit will be provided during the 12- month period following the date of loss of coverage under the Fund, if the patient continues to be disabled.

For HMO enrollees: If your HMO Plan does not cover a Medically Necessary artificial limb or Orthopedic Appliance, and the artificial limb or Orthopedic Appliance would be covered under the Indemnity Medical Plan, the Fund will provide coverage in accordance with the benefits provided under the Indemnity Medical Plan. To be reimbursed by the Fund for these benefits, you must provide the Fund Office with a copy of the denial letter(s) from your HMO Plan showing that the HMO Plan did not provide coverage for the artificial limb or Orthopedic Appliance.

This benefit is also described in the "Artificial Limbs & Orthopedic Appliances" row of the Schedule of Medical Benefits for the Indemnity Medical Plan, at Section 16 of "The Indemnity Medical Plan" Chapter of this booklet.

IX
DENTAL BENEFITS

In this Chapter, the terms "you" and "your" refer to the Employee.

Participants who are eligible for dental benefits have a choice between the Indemnity Dental Plan and the United Concordia Dental HMO Plan. You and your covered Dependents must be enrolled in the same dental plan.

Your dental plan selection is made at the time of initial enrollment and may be changed during a subsequent Open Enrollment period or if you or your Dependent has a Special Enrollment right.

If you fail to elect a dental plan at the time of initial enrollment, you and any of your Dependents will be enrolled in the Indemnity Dental Plan.

Note: You are permitted to opt-out of dental coverage for yourself and your Dependents. However, opting out of dental benefits will not change the amount of your employee premium.

1. The United Concordia Dental HMO Plan

If you elect dental coverage under the United Concordia Dental HMO Plan, you and your enrolled Dependents will receive all of your dental benefits under the United Concordia Dental HMO Plan.

Information about the United Concordia Dental HMO Plan is included in the initial enrollment packet that is mailed to you after you start work in Covered Employment.

This booklet does not describe the dental benefits available under the United Concordia Dental HMO Plan. For detailed information about those benefits, please refer to the Certificate of Insurance issued by United Concordia. Call United Concordia using the number listed in the Quick Reference Chart at the beginning of this booklet for a copy of the Certificate of Insurance.

If there is a conflict between any description of dental benefits in this booklet and United Concordia's EOC or the Fund's contract with United Concordia, the Certificate of Insurance and the Fund's contact with United Concordia will control.

2. The Indemnity Dental Plan

This Section provides a brief description of the dental benefits provided under the Indemnity Dental Plan. For a full explanation, please review the Delta Dental Combined Evidence of Coverage and Disclosure Form for the Southern California Drug Benefit Fund (referred to as the "Delta Dental EOC"), which is available upon request from the Fund Office.

The Delta Dental EOC is incorporated into this booklet by reference and made part of this Summary Plan Description and Plan Document. ***If there is a conflict between any description of the dental benefits provided under the Indemnity Dental Plan in this booklet and the Delta Dental EOC or the Fund's contract with Delta Dental, the Delta Dental EOC and the Fund's contract with Delta Dental will control.***

The Indemnity Dental Plan is administered by Delta Dental, but all benefits are paid on a self-funded basis by the Fund.

If you elect dental coverage under the Indemnity Dental Plan, you and your enrolled Dependents will receive all of your dental benefits under the Indemnity Dental Plan, as described in this Section.

A. Dental Network

The Fund contracts with Delta Dental of California to bring you an expansive network of dentists.

Under the Indemnity Dental Plan, you and your Dependents may receive dental care from any dentist. However, your costs will generally be lowest if you and your Dependents use dentists in the Delta Dental PPO Network. You and your Dependents may also use dentists in the Delta Dental Premier Network, at a higher out-of-pocket cost, or dentists who are not affiliated with Delta Dental (i.e., non-Delta Dental dentists), which is generally the costliest option.

To find a dentist in the Delta Dental network, go to www.deltadentalins.com or call Delta Dental at (888) 335-8227.

B. Benefits, Limitations, and Exclusions

The Indemnity Dental Plan covers services provided by a licensed dentist that are necessary and customary under the generally accepted standards of dental practice, subject to the limitations and exclusions set forth in the Delta Dental EOC.

Benefits are payable for dental services for which an allowance is provided in the Fund's Dental Schedule of Allowances. The Fund does not cover dental services not listed in the Dental Schedule of Allowances, or services for which no allowance is listed in the Dental Schedule of Allowances. The most current Dental Schedule of Allowances is available on the Fund's website at www.ufcwdrugtrust.org. You can also call the Fund Office to request a free copy.

C. Annual Deductible

The Indemnity Dental Plan has an annual Deductible of $75 per individual and $225 per family. The dental Deductible is not applicable to routine preventative and diagnostic procedures such as oral examinations, teeth cleanings, and x-rays.

Once you or your Dependent has satisfied the individual Deductible, covered dental services will be paid at 100% of the Eligible Expense for your or your Dependent, as applicable, subject to the $2,000 annual dollar limit (described in subsection E, below). Once your family Deductible is satisfied, the individual Deductible will be considered satisfied with respect to you and each of your covered Dependents.

D. Eligible Expenses

The Indemnity Dental Plan pays 100% of Eligible Expenses for covered dental services, excluding amounts used to satisfy the individual or family Deductible, until the Participant reaches their $2,000 annual dollar limit on benefits (described in subsection E, below), if applicable.

The Eligible Expense for any dental service depends on whether a Delta Dental PPO dentist, a Delta Dental Premier dentist, or a non-Delta Dental dentist is used, but will never be more than the Fund's scheduled allowance for the covered service. Specifically, the Eligible Expenses is as follows:

(1) **For services received from Delta Dental PPO dentists**: The Fund pays the lesser of: (a) the Delta Dental PPO contracted rate; or (b) the allowance listed in the Fund's Dental Schedule of Allowances.

(2) **For services received from Delta Dental Premier dentists**: The Fund pays the lesser of: (a) the Delta Premier filed fee; or (b) the allowance listed in the Fund's Dental Schedule of Allowances. (Note, the filed fees for Delta Dental Premier dentists are generally higher than the Delta Dental PPO contracted rates).

(3) **For services received from any other dentists (i.e., non-Delta Dental dentists):** The Fund pays the lesser of: (a) the amount billed by the dentist; or (b) the allowance listed in the Fund's Dental Schedule of Allowances.

You (and your Dependents, as applicable) are responsible for any charges that exceed Eligible Expenses. In addition, the Indemnity Dental Plan will not pay for any Eligible Expenses once the Participant has reached the annual dollar limit (described in subsection E, below), if applicable.

E. Annual Dollar Limit (Benefit Maximum) for Adult Participants

Participants age 19 and older are subject to an annual dollar limit on benefits of $2,000. Once the Fund pays $2,000 in a calendar year for dental benefits for any Participant age 19 or older, no further dental benefits will be payable for that calendar year. The annual dollar limit is not applicable to Participants younger than 19 years of age.

F. Predeterminations

If the service you are seeking is extensive and involves crowns or bridges, or if the service will cost more than $300, you are encouraged to ask your dentist to request a predetermination from Delta Dental.

A predetermination does not guarantee payment. It is an estimate of the amount the Fund will pay if you are eligible and meet all the requirements for coverage at the time the treatment you have planned is completed.

To receive a predetermination, your dentist must submit a claim form listing the proposed treatment to Delta Dental. Delta Dental will then send your dentist a "Notice of Predetermination," which provides an estimate of the benefits payable for the proposed treatment, and how much you will have to pay. If, after reviewing the estimate with your dentist, you decide to go ahead with the treatment plan, your dentist will return the form to Delta Dental once treatment has been completed.

Computations are estimates only and are based on the benefit that would be payable on the date the Notice of Predetermination is issued if the individual is eligible. The actual payment will depend on the individual's eligibility when services are completed.

If you have any concerns about a predetermination, contact Delta Dental before treatment begins so your questions can be answered before you incur any charges.

G. Claims and Appeals

All dental claims under the Indemnity Dental Plan must be submitted directly to Delta Dental, P.O. Box 997330, Sacramento, CA 95899-7330. Delta Dental dentists will file the claim for you. For non-Delta Dental dentists, you are responsible for paying the dentist and then filing a claim for reimbursement

from Delta Dental.

Dental claims must be filed within 12 months after the completion of dental procedures. Claims must show procedure codes (adapted from the ADA recommended current Dental Terminology CDT) and the actual fee charged to the patient.

Claims that do not meet the above requirements will be denied.

If your claim is denied, in whole or in part, you may file a request for review (i.e., an appeal) with Delta Dental in accordance with Delta Dental's appeal procedures. For a copy of Delta Dental's appeal procedures, call Delta Dental at 888-335-8227, write to Delta Dental at P.O. Box 997330, Sacramento, CA 95899-7330, Attention: Customer Service Department, or contact Delta Dental on its website at deltadentalins.com.

X
THE DEATH BENEFIT PLAN

In this Chapter, the terms "you" and "your" refer to the "Eligible Employee," as defined in Section 1, below. However, with respect to the Felonious Death Benefit, the terms "you" and "your" refer to an Employee whose Employer is required to make contributions to the Fund on behalf of the Employee under the terms of a Collective Bargaining Agreement at the time of the felonious assault.

This Chapter is a summary of the Death Benefit Plan of the Southern California Drug Benefit Fund and is not intended to be a complete statement of the rules and regulations governing these benefits. For a full explanation of the Death Benefit Plan, please refer to the official plan document, entitled "Southern California Drug Benefit Fund Death Benefit Plan (Amended and Restated as of December 1, 2010)." The official plan document is incorporated into and made part of this booklet by reference. In the event of any conflict between this Chapter and the official plan document for the Death Benefit Plan, the plan document will control. Subject to the Collective Bargaining Agreement and applicable law, the Trustees reserve the right to amend, suspend, or terminate all or any part of these benefits at any time.

The following benefits are available under the Death Benefit Plan: (1) the Employee Death Benefit; (2) the Total and Permanent Disability Death Benefit; (3) the Felonious Death Benefit; and (4) the Dependent Death Benefit. Each of these death benefits is described in more detail below.

1. Death Benefit Plan Definitions

Whenever the following capitalized terms are used in this Chapter, they have the meanings shown below.

A. **Beneficiary(ies):** The person(s) whom you designate in accordance with Section 4 ("Designation of Your Beneficiary") of this Chapter, below, to receive benefits under the Death Benefit Plan in the event of your death.

B. **Covered Dependent:** An individual who is covered as your Dependent under the Fund at the time of such individual's death.

C. **Credited Service:** The service you earn in a calendar year for work in Covered Employment. For each 150 hours worked in a calendar year, you earn 1/12 of a year of Credited Service. If you work 1800 hours or more in a calendar year, you will earn a maximum of one year of Credited Service.

D. **Eligible Employee:** An Employee who is covered under the Fund.

2. Benefits in the Event of the Death of an Eligible Employee

A. Employee Death Benefit

If you are an Eligible Employee at the time of your death, the Fund will pay an Employee Death Benefit to your Beneficiary. The amount of the Employee Death Benefit will be the greater of: (1) $15,000; or (2) one year's wages, calculated by multiplying your hourly wage by the hours you worked during the most recent 12 months. If there is more than one Beneficiary, the amount of the Death Benefit will be divided equally among all Beneficiaries.

B. Total and Permanent Disability Death Benefit

If you become totally and permanently disabled while you are an Eligible Employee, then a $10,000 Total and Permanent Disability Death Benefit will be payable upon your death (and the Retiree Death Benefit will not be available), provided that the following requirements are satisfied:

(1) You earned a minimum of five (5) years of Credited Service before your disability began.

(2) Your disability began before you reached age 70.

(3) You were an Eligible Employee on the date you applied for the Total and Permanent Disability Death Benefit, or you submitted your application within 30 days after (i) the effective date of pension benefits awarded under the Southern California United Food and Commercial Workers Unions and Drug Employers Pension Plan or (ii) a termination of Covered Employment.

(4) You became disabled while you were an Eligible Employee, and your disability continued for a 6-consecutive month period immediately following its inception.

(5) **Annual Certification of Continuing Disability.** You furnish the Fund Office with written proof of your continuing disability by the last business day of December of each year following the year in which you applied for this benefit. The proof will be in the form of a signed statement from a physician indicating that you continue to be totally and permanently disabled or such other proof as the Trustees may accept. The Trustees may waive this requirement on an individual basis if they determine that circumstances warrant a waiver.

You are considered **totally and permanently disabled** if you suffer a physical or mental disease or injury that prevents you from engaging in any occupation or employment for wages or profit, and the Trustees receive acceptable proof from a physician that your disability is likely to be permanent, continuous, and total during the rest of your life. The Trustees may require you to be examined by a physician or to submit medical or other records for review by a medical consultant in determining whether you are totally and permanently disabled. The Trustees may rely on the opinion of a medical consultant but have the sole authority to determine whether you are totally and permanently disabled.

An application for the Total and Permanent Disability Death Benefit may be obtained by contacting your Local Union Insurance Office or the Fund Office.

Circumstance Resulting in Loss of Eligibility or Disqualification for Benefits

- If you engage in any work for wage or profit, your eligibility for the Total and Permanent Disability Death Benefit will terminate on the first day such work is performed.

- If you fail to provide annual certification of your continuing disability, as described in paragraph (5) above, your eligibility for the Total and Permanent Disability Death Benefit will terminate on the first day of the first calendar year following the year in which no annual certification was received by the Fund Office by December, unless the Trustees have waived the requirement for you to provide such certification.

- Your eligibility for the Total and Permanent Disability Death Benefit will terminate upon the date you are no longer totally and permanently disabled.

- You are not eligible for the Total and Permanent Disability Death Benefit if you are eligible for the Employee Death Benefit described in Section 2.A of this Chapter, above.

C. Felonious Death Benefit

If you die due to injuries received because of a felonious assault by another person that occurred while you were performing your job duties in Covered Employment, the Fund will pay a Felonious Death Benefit of $60,000 to your Beneficiary, provided that your death occurs within 180 days from the date of the felonious assault. The Felonious Death Benefit will be paid even if you were not an Eligible Employee at the time of the felonious assault, so long as your Employer was required to make contributions to the Fund on your behalf under a Collective Bargaining Agreement. The Felonious Death Benefit is not a Workers' Compensation benefit.

If you qualify for the Employee Death Benefit described in Section 2.A of this Chapter, above, then the larger of the Employee Death Benefit or the Felonious Death Benefit will be paid, but not both.

The Felonious Death Benefit will not be paid for deaths resulting from:

(1) Intentionally self-inflicted injuries, suicide, or any attempt thereof, while sane or insane, whether or not intoxicated;

(2) An act of declared or undeclared war;

(3) Your commission of, or attempt to commit or to participate in, assault or felony; or

(4) Illness, disease, pregnancy, childbirth, miscarriage, bodily infirmity, or any bacterial infection, other than occurring as a consequence of a wound incurred as a result of a felonious assault.

3. Benefit in the Event of the Death of a Covered Dependent

If your Covered Dependent dies while you are an Eligible Employee, you will be paid a $2,000 Dependent Death Benefit. No benefits are payable for a fetal death.

In the event of the simultaneous deaths of you (the Employee) and your covered Dependent, the Fund will pay, in lieu of the Dependent Death Benefit, the reasonable costs of burial, not to exceed $2,000.00. The reasonable costs of burial will be paid to the person who actually incurred the burial expenses.

4. Designation of Your Beneficiary

You may designate one or more Beneficiaries to receive the death benefits in the event of your death. A Beneficiary must be a natural person or your estate. A designation of an organization will not be accepted. If you designate more than one Beneficiary, the amount of the death benefit will be divided equally among all Beneficiaries. You are the Beneficiary in the event of a Covered Dependent's death.

To designate a Beneficiary, you must submit a properly completed Beneficiary Designation Form to the Fund Office. This form is available on the Fund's website. You may also call your Local Union Insurance Office or the Fund Office to request a form.

Please make sure that you have designated as your Beneficiary(ies) the individual(s) whom you wish to receive your death benefit and that your Beneficiary designation is current. For example, if you designate a Beneficiary who dies before you, a new Beneficiary Designation Form should be completed and filed with the Fund Office. If you designate your Spouse as a Beneficiary and later get divorced, that designation will remain in effect unless you change your Beneficiary by completing a new Beneficiary Designation Form and submitting it to the Fund Office.

If your Beneficiary is a minor, the applicable death benefit will be paid to the guardian of the estate of the child, pursuant to an appropriate order, or to the child when the child turns 18 years of age.

You should advise your Beneficiary(ies) to contact your Local Union Insurance Office or the Fund Office in the event of your death, for information concerning the death benefit payment available under this plan.

If you do not designate a Beneficiary, if your designated Beneficiary(ies) dies before you, or if you and your designated Beneficiary(ies) die at the same time, the Death Benefit Plan provides that the death benefit shall be payable in the following order:

(1) Your Spouse or Domestic Partner. If none, then

(2) Your natural children, including legally adopted children, in equal shares. If none, then

(3) To your parents, including adoptive parents, in equal shares. If none of the above, then

(4) No death benefit is payable. However, the Fund will pay a reasonable amount, as determined by the Trustees, to the person who presents proper evidence that he or she has actually incurred expenses for your burial, to reimburse them for such expense. In no event will the Fund pay more than the total amount of the Employee Death Benefit payable under Section 2.A of this Chapter, above, for burial expenses.

5. Exclusions and Limitations

In the event your Beneficiary is convicted of the murder or voluntary manslaughter of you or your Dependents, such Beneficiary will not be entitled to any death benefit which would otherwise be payable under the Death Benefit Plan.

In the event of fetal death, no benefits are payable.

The total amount of benefits payable under this Death Benefit Plan is limited to $1 million per occurrence, in the event that benefits are payable upon the death of multiple Employees as the result of a single occurrence.

6. How to File a Claim for a Death Benefit

In the event of your death, your Beneficiary(ies) should contact the Fund Office or a Local Union Insurance Office to file a Claim for the applicable death benefit.

In the event of the death of one of your covered Dependents, please contact the Fund Office or your Local Union Insurance Office to file a Claim for the Dependent Death Benefit.

Claims for a death benefit must be filed with the Fund Office within one (1) year of the date of the decedent's death. A certified Certificate of Death for the decedent is required before any benefits are paid.

For a full explanation of the claims and appeals procedures applicable to Claims for benefits under the Death Benefit Plan, please see Section 6 ("Non-Health Claims – Claims and Appeals Procedures") of the "Claims and Appeals Procedures & the External Review Process" Chapter of this booklet.

XI
SUPPLEMENTARY DISABILITY & UNEMPLOYMENT BENEFITS (PLATINUM PARTICIPANTS ONLY)

In this Chapter, the terms "you" and "your" refer to the Employee who is covered under the Platinum Plan of the Fund.

This Chapter is a summary of the Supplementary Disability and Unemployment Plan of the Southern California Drug Benefit Fund (referred to as the "Supplementary Plan") and is not intended to be a complete statement of the rules and regulations governing these benefits. For a full explanation of the Supplementary Disability and Unemployment Plan, please refer to the official plan document, entitled "Southern California Drug Benefit Fund Supplementary Disability and Unemployment Plan (Amended and Restated as of March 1, 2016)." The official plan document is incorporated into and made part of this booklet by reference. In the event of any conflict between this Chapter and the official plan document for the Supplementary Disability and Unemployment Plan, the plan document will control. Subject to the applicable provisions of the official plan document, the Trust Agreement, and other governing documents, the Trustees have the right to amend, suspend, or terminate all or any part of these benefits at any time.

1. Supplementary Plan Definitions

Whenever the following capitalized terms are used in this Chapter, they have the meanings shown below.

California State Base Period. The California State Base Period is the period used by the State of California to determine the amount of your weekly State disability or unemployment benefits. The California State Base Period is determined as follows:

If the State claim is established in:	The California State Base Period is the 12-month period ending the preceding:
Oct., Nov., or Dec.	June 30
Jan., Feb., or Mar.	September 30
Apr., May, or June	December 31
July, Aug., or Sept.	March 31

Supplementary Plan: The Supplementary Disability and Unemployment Plan of the Southern California Drug Benefit Fund.

Supplementary Benefits: Benefits provided under the Supplementary Plan, which include Supplementary Disability, Supplementary Unemployment, and Supplementary Workers' Compensation benefits.

2. Eligibility

The benefits described in this Chapter are available only to Employees who are Participants in the Platinum Plan. These benefits are not available to Dependents.

A. Supplementary Disability & Unemployment Benefits

To be eligible for Supplementary Disability or Unemployment benefits, you must satisfy the following requirements:

(1) You must be covered under the Platinum Plan of the Fund in either:

(a) The month in which your claim for State disability benefits (or your claim for disability benefits from a State-approved voluntary plan) is established; or

(b) The month in which (or the month immediately before the month in which) your claim for State unemployment benefits is established.

(2) You must actually receive State disability benefits (or disability benefits from a State-approved voluntary plan) or State unemployment benefits for the same period for which Supplementary Benefits are claimed.

(3) You must have worked in Covered Employment for:

(a) 400 hours in the 6 calendar months immediately prior to the calendar month in which your claim is established by the State; or

(b) 700 hours in the 12 calendar months immediately prior to the calendar month in which your claim is established by the State; or

(c) 1,000 hours in the 18 calendar months immediately prior to the calendar month in which your claim is established by the State.

(4) You must have earned sufficient income in Covered Employment during your California State Base Period to qualify for State disability or unemployment benefits.

(5) A period of military service will be "lifted out" of the qualifying period indicated in paragraph (3) of this Section 2.A, above. Hours worked in Covered Employment before and after such military service will be used toward meeting the hourly requirements.

(6) You must submit an application for Supplementary Benefits, as well as the following documentation, as applicable, to the Fund Office:

For Supplementary Disability Benefits:	***For Supplementary Unemployment Benefits:***
⇒ *Notice of Computation from the Employment Development Department (EDD)* ⇒ *Record of Disability Benefits Paid (payment stubs or other proof of disability payments)* ⇒ *Any notices concerning changes to your benefits*	⇒ *Notice of Unemployment Insurance Award from the Employment Development Department (EDD)* ⇒ *Check stubs or photocopies of your State Unemployment Checks*

After you submit your application and the required documentation, you will need to continue to submit paystubs or copies of checks showing benefit payments to you from the State (or from the State-approved voluntary plan) to continue receiving benefits.

B. Additional Rules Applicable to Supplementary Unemployment Benefits

The following additional rules apply to Supplementary Unemployment benefits:

(1) A period during which you received paid Supplementary Disability benefits will count as time worked in meeting any of the hours requirements listed in paragraph (3) of Section 2.A of this Chapter, above, for Supplementary Unemployment benefits.

(2) If you established a Claim for Supplementary Unemployment benefits within 18 months before the date of a new Supplementary Unemployment Claim, you must have worked a minimum of 700 hours in Covered Employment within the 12 completed calendar months immediately prior to the date your new claim for State unemployment benefits was established.

(3) If you were disqualified from receiving State unemployment benefits, you will be eligible to receive Supplementary Unemployment benefits after all the following conditions have been met:

(a) The State disqualification is removed;

(b) You have returned to work in Covered Employment and have earnings which are equal to five times the weekly State unemployment benefit for which you would have otherwise qualified; and

(c) You otherwise satisfy the eligibility requirements for Supplementary Unemployment benefits.

C. Supplementary Workers' Compensation Benefits

To be eligible for Supplementary Workers' Compensation Benefits, you must satisfy the following requirements:

1. You must have sustained an injury or illness as a result of working in Covered Employment.

2. You must have coverage under the Platinum Plan in the month in which you sustained the injury or illness as a result of working in Covered Employment.

3. You must be receiving temporary disability benefits from your Employer's Workers' Compensation carrier that are allocated to a specific period of time.

4. You must submit an application for Supplementary Benefits, as well as the following documentation, as applicable, to the Fund Office:

⇒ *Notice of Award or Approval Letter from the Workers' Compensation carrier; and*

⇒ *Copies of check stubs from Workers' Compensation carrier; and*

⇒ *Any other notices concerning changes to your benefits.*

After you submit your application and the required documentation, you will need to continue to submit paystubs or copies of checks showing benefit payments to you from the Workers' Compensation carrier to continue receiving benefits.

D. Circumstances Under Which Supplementary Benefits are Not Payable

Notwithstanding the above, you will not be eligible to receive Supplementary Benefits in the following circumstances:

1. If you are receiving a pension from the Drug Pension Plan or the General Sales Pension Plan, you are not eligible for Supplementary Benefits during a period for which pension benefits are payable.

2. If you fail to submit a Claim for Supplementary Disability or Supplementary Unemployment benefits within one year after the date of your State disability claim (or disability claim from a State-approved voluntary plan) or State unemployment claim is established.

3. If you fail to submit a Claim for Supplementary Workers' Compensation benefits within one year after the date your Workers' Compensation claim is established or within one year after the date of the first payment by the Workers' Compensation carrier, whichever date is later. (A Claim is considered received by the Fund on the date it is postmarked or hand-delivered to the Fund Office or to a Local Union Insurance Department office.)

4. If you receive a lump sum payment from the Workers' Compensation carrier in settlement of a claim which is specified as temporary disability benefits not attributed to a specific period of time.

5. If you are receiving Workers' Compensation permanent disability benefits.

6. If you were employed as a Pharmacist, you are not eligible for Supplementary Unemployment benefits.

3. Benefits

A. Supplementary Benefit Amount

Benefits provided under the Supplementary Plan will be paid on a weekly basis.

- If you are a Pharmacist, you will be paid $10.44 for each calendar day for which Supplementary Benefits are payable.

- If your Covered Employment was in a position other than as a Pharmacist, you will be paid $2.58 for each calendar day for which Supplementary Benefits are payable.

- If you received reduced State unemployment benefits, it will not affect the amount of your Supplementary Benefit for the week.

The Supplementary Benefit amounts shown above may be changed by the Board of Trustees from time to time. In addition, the Trustees, at their discretion, may reduce the duration of the benefit period, or suspend or reduce benefit payments as may be deemed necessary, in accordance with the terms of the Supplementary Plan.

B. Time Limits Applicable to Payment of Supplementary Benefits

Supplementary Disability and Unemployment benefits are payable only for the period during which you actually receive State disability benefits (or disability benefits from a State-approved voluntary plan) or

State unemployment benefits, excluding any period of extended duration State unemployment benefits. In addition, the duration of payment for Supplementary Benefits will not exceed the following:

- Supplementary Disability benefits are payable for a maximum of 9 months for each State disability claim (or disability claim under a State-approved voluntary plan).

- Supplementary Unemployment benefits are payable for a maximum of 6 months for each State unemployment claim.

- Supplementary Workers' Compensation benefits are payable for a maximum of 12 months for each Workers' Compensation claim.

- If you are concurrently receiving State disability benefits and Workers' Compensation benefits for which Supplementary Benefits are payable, then Supplementary Workers' Compensation benefits will be payable for a maximum of 12 months, and Supplementary Disability benefits will not be payable.

Once you have exhausted this 6-, 9-, or 12-month maximum, you must return to Covered Employment and work Qualifying Hours each month for two consecutive months before you can qualify for a new Claim for Supplementary Benefits.

If your Supplementary Disability or Supplementary Workers' Compensation benefits end before you have exhausted the 9- or 12-month maximum, as applicable, and you again become disabled following a return to work, you may qualify to receive the remainder of your 9- or 12-month period for which Supplementary Disability or Supplementary Workers' Compensation benefits are payable, provided that you receive State disability or temporary disability benefits from the Workers' Compensation carrier for the same period.

If, after you have exhausted the maximum period of Supplementary Disability or Workers' Compensation benefits, you return to Covered Employment and work Qualifying Hours each month for two consecutive months, you can again qualify to receive Supplementary Disability or Workers' Compensation benefits, regardless of whether you establish a new State disability claim (or a new disability claim from a State-approved voluntary plan), as long as you receive State disability benefits (or disability benefits from a State-approved voluntary plan) or temporary disability benefits from the Workers' Compensation carrier for the same period.

4. Miscellaneous

If you are appealing the denial of a Workers' Compensation claim and receive State disability benefits on a "lien" basis pending the outcome of the Workers' Compensation Appeals Board decision, you will be eligible to receive Supplementary Benefits, as long as you otherwise qualify under the terms of the Supplementary Plan. If your Workers' Compensation claim is subsequently awarded, you will not be required to repay Supplementary Disability benefits to the Fund. However, the period of time during which you received Supplementary Disability benefits will be deducted from the maximum period of time for which Supplementary Workers' Compensation benefits are payable.

XII
COORDINATION OF BENEFITS (COB): OTHER COVERAGE AND DUAL COVERAGE

In this Chapter, the terms "you" and "your" refer to the Employee.

1. What Is Coordination of Benefits and When Does It Apply?

This Chapter describes the Fund's coordination of benefits ("COB") rules applicable to benefits provided under the Indemnity Medical Plan. These COB rules do not apply to benefits provided by the Fund-sponsored HMO Plans (the Kaiser HMO or the UnitedHealthcare HMO). In addition, these COB rules do not apply to Health Claims for Prescription Drugs.

These COB rules apply when the Fund processes a Health Claim of a Participant who (i) also has health coverage under a plan, policy, or program that is not provided by the Fund (referred to as "Other Coverage" and defined in Section 2, below) or (ii) has "Dual Coverage" under this Fund (as defined below).

These COB rules are used to determine (i) whether the Fund's Plan is primary (i.e., pays benefits first without regard to the amount paid by the Other Coverage) or secondary (i.e., pays benefits second, after the Other Coverage pays) when a Participant has Other Coverage, (ii) the limits on the Fund's payment obligations when a Participant has Other Coverage, (iii) which Fund Plan is primary when a Participant has Dual Coverage, and (iv) benefits payable when a Participant has Dual Coverage.

The Fund will not pay any benefits for a service or supply that is not covered under the Plan, even if such service or supply is covered under the Other Coverage.

These COB rules are subject to the provisions in the Chapters of this SPD entitled "Excluded Services and Limitations" and "Workers' Compensation & Third Party Liability."

You or your Dependent must notify the Fund Office if you or your Dependent(s) have Other Coverage.

2. Definition of Other Coverage

A. What Is Other Coverage?

Other Coverage includes, but is not limited to, the following: (1) coverage under a group or group-type health plan, insurance policy or contract, program, or other arrangement (including group coverage under an HMO) that provides payment or reimbursement for Hospital, medical, mental health and/or substance use disorder, dental, and/or vision expenses; (2) the medical care components of a long-term care contract, such as skilled nursing care; and (3) coverage under Medicare, Medicaid, a state Children's Health Insurance Program ("CHIP"), TRICARE, or any other federal or state governmental plan, if the Fund is permitted by law to coordinate benefits.

B. What Does Not Constitute Other Coverage?

Other Coverage generally does not include the following: (1) coverage under an individual (i.e., non-group) plan or policy (including coverage under an individual HMO plan); (2) Hospital indemnity

coverage or other fixed indemnity coverage; (3) accident only coverage; (4) specified disease or specified accident coverage; (5) limited benefit health coverage, as defined by state law; (6) school accident type coverage; (7) benefits for non-medical components of long-term care policies; (8) medical benefits under a group or individual motor vehicle insurance contract; (9) third party liability insurance; (10) blanket insurance contracts issued pursuant to Section 10270.2(b) or (e) of the California Insurance Code that contain a non-duplication of benefits or excess policy provision; or (11) Medicare supplement policies or coverage under other federal or state governmental plans, unless coordination with such coverage is permitted by law.

3. The Working Spouse Rule

If there is other employment-related group health plan coverage available to your Spouse/Domestic Partner, he or she is generally required to enroll in that plan. Otherwise, the benefits payable under this Plan will be significantly reduced. For more information on the Working Spouse Rule, see the Chapter entitled "Eligibility Rules," Section 4 ("Dependent Coverage"), Subsection E ("The Working Spouse Rule").

4. Non-Duplication of Benefits

The Fund uses a "non-duplication of benefits" rule when it coordinates coverage provided under this Plan with Other Coverage. Under "non-duplication of benefits," when a Participant has Other Coverage, the Fund's payment will never exceed its "Normal Benefit," which is the amount that it would have paid if there had been no Other Coverage involved.

A. The Fund's Payment under Non-Duplication

Under the "non-duplication of benefits" rule, the Fund's payment will be determined as follows:

(1) If this Plan Is Primary

When this Plan is primary to the Other Coverage, the Fund will pay its Normal Benefit as if no Other Coverage was involved.

(2) If the Other Coverage Is Primary

When this Plan is secondary to the Other Coverage (i.e., the Other Coverage is primary), then benefits will be determined as follows:

(a) If the amount paid by the Other Coverage is less than the Normal Benefit provided under this Plan, then the Fund will pay the difference between its Normal Benefit and the amount paid by the Other Coverage.

(b) If the amount paid by the Other Coverage is the same as or greater than the Normal Benefit provided under this Plan, then the Fund will not pay any benefits.

In determining the amount of the Plan's Normal Benefit for this purpose, the Plan's Allowed Amount will not exceed the charge allowed by the Other Coverage, with one exception: if the Other Coverage has entered into a preferred provider agreement with a medical or Hospital Provider, the Plan's Normal Benefit will be the lesser of (a) the normal charges billed for the expense by the Provider or (b) the contractual rate for such expense under the preferred provider agreement between the Provider and the Other Coverage. The Board of Trustees, in determining benefits under this Fund, will disregard any provision in the preferred provider agreement entered into by

the Other Coverage that would frustrate the intent of this language.

(3) Coordination with HMO Plans

The coordination rules applicable when the Other Coverage is from an HMO are addressed in Section 9 of this Chapter.

B. Examples of Non-Duplication

The following examples assume that your Other Coverage is primary and that all Deductibles have been met, but your medical Out-of-Pocket Maximum has not been reached.

Example 1: *Your Other Coverage pays 50%, and the Fund usually pays 80% for medical treatment under the Plan. If you have covered medical expenses, your Other Coverage will pay 50%, and the Fund will pay 30%, which is the difference between the Fund's payment of 80% and the 50% paid by the Other Coverage. You will pay the remaining 20%.*

Example 2: *If your Other Coverage pays 80%, and the Fund usually pays 80%, the Fund will not pay anything since the amount paid by the Other Coverage is the same as what the Fund would have paid if the Plan were primary. You will pay the remaining 20%, even though two plans were involved.*

5. Dual Coverage

The Fund will not apply the "non-duplication of benefits" rule when it processes Health Claims of a Participant who has Dual Coverage.

A. What is Dual Coverage?

A Participant has Dual Coverage if:

(1) The Participant has coverage under the Fund both as an Employee and as the Dependent of an Employee, **and** both Employees are enrolled in family coverage under the Indemnity Medical Plan (e.g., you are covered as an Employee and as the Dependent of your Spouse/Domestic Partner, who is also an Employee with Fund coverage, and both of you have enrolled in family coverage under the Indemnity Medical Plan); or

(2) The Participant has coverage under the Fund as a Dependent of two Employees, **and** both Employees have family coverage under the Indemnity Medical Plan (e.g., the Participant is a Child whose two parents are both Employees with Fund coverage, each of whom have enrolled the Child in family coverage under the Indemnity Medical Plan). If the two parents are divorced or unmarried, they may be enrolled in Employee-child coverage only.

B. Full Coordination of Benefits Applies to Dual Coverage

When a Participant has Dual Coverage, the Fund will apply full coordination of benefits to the Participant's Claims. Full coordination may make it possible for the Fund to pay up to 100% of the Contract Rate(s)/Allowed Amount(s) for Claims subject to the Dual Coverage rules.

In all cases, the combined payment amount (i.e., the combined amount paid by both Fund Plans) will never exceed the Fund's Contract Rate(s)/Allowed Amount(s) for the Claim(s) at issue.

PLEASE NOTE THAT THE "DUAL COVERAGE" RULES SHOWN ABOVE DO NOT APPLY IF:

- Both you and your Spouse/Domestic Partner are enrolled in the Indemnity Medical Plan, but both of you are NOT enrolled in family coverage (meaning you do not both have family coverage).

- You are enrolled in the Indemnity Medical Plan and your Spouse/Domestic Partner is enrolled in a Fund-sponsored HMO Plan, or vice versa. If a Participant has coverage under the Fund's Indemnity Medical Plan and one of the Fund's HMO Plans, Section 9 ("Special Rules for Coordination with Prepaid Programs") of this Chapter, below, will govern the payment of benefits by the Indemnity Medical Plan.

- Both you and your Spouse/Domestic Partner are enrolled in a Fund-sponsored HMO Plan.

6. Reimbursement for "Double Coverage" under the Fund's HMO Plans

If you have coverage under one of the Fund's HMO Plans (either the Kaiser HMO or the UHC HMO) both as an Employee and as the Dependent of an Employee, or if your Dependent has coverage under one of the Fund's HMO Plans as the Dependent of two Employees, the Fund will reimburse your (or, as applicable, your Dependent's) copays and/or coinsurance incurred under the HMO.

In order to qualify for this reimbursement, you (or your Dependent, as applicable) must have "double coverage" under the same Fund HMO Plan, meaning you have coverage under either the Kaiser HMO or the UHC HMO, both as an Employee and as the Dependent of an Employee (or your Dependent has coverage under either the Kaiser HMO or the UHC HMO as the Dependent of two Employees, each of whom are enrolled in family coverage under the same Fund HMO Plan).

Example: *You are covered under the Fund's Kaiser HMO Plan as an Employee. You are also covered under the Fund's Kaiser HMO Plan as the Dependent of your Spouse, who is also an Employee with Fund coverage. Both of you have enrolled in family coverage under the Fund's Kaiser HMO Plan. The Fund will reimburse the copays and coinsurance incurred by you and your Spouse under the Kaiser HMO Plan.*

Please contact the Fund Office for information about how to submit a claim to have your HMO expenses reimbursed by the Fund.

7. No COB Credit Banks

This Fund **does not** administer a benefit reserve (also called a benefit bank, credit balance, credit reserve, savings bank, or credit savings) calculation in the coordination of benefits.

8. Which Plan Pays First: Order of Benefit Determination Rules

When a Participant has Other Coverage, the Fund will apply the following order of benefit determination rules to establish which plan is the primary plan that pays first and which plan is the secondary plan that pays second. These rules will also be applied when a Participant has Dual Coverage to determine which Fund Plan is primary and which Fund Plan is secondary. If Rule 1 does not establish an order of benefits, the next rule (i.e., Rule 2) will be applied, and so on, until an order of benefits is established.

Except as specifically provided to the contrary in this Chapter, if the Other Coverage does not have any COB rules, then the Other Coverage is automatically primary. However, when the Other Coverage is provided under a prepaid program, Medicare, Medicaid, a state Children's Health Insurance Program (CHIP), TRICARE, or another government program, different rules will apply, as specified below in

Section 11 ("Coordination of Benefits with Medicare") and Section 12 ("Coordination with Government and Other Programs") of this Chapter.

This Fund's order of benefit determination rules are as follows:

A. Rule 1: Non-Dependent or Dependent

(1) The plan that covers the Participant as a non-dependent (for example, as an active employee, retiree, member, or subscriber) is the primary plan that pays first, and the plan that covers the same person as a dependent is the secondary plan that pays second, except when Rule 3 applies.

(2) If the Participant is also a Medicare beneficiary, and as a result of the provisions of Title XVIII of the Social Security Act and implementing regulations (the Medicare rules), Medicare is secondary to the plan covering the Participant as a dependent and primary to the plan covering the Participant as a non-dependent (that is, the plan covering the Participant as a retired employee), then the plan covering the Participant as a dependent pays first, Medicare pays second, and the plan covering the same person as a non-dependent (that is, as a retired employee) pays third.

B. Rule 2: Child Covered Under More Than One Plan

If your covered Child also has Other Coverage or has Dual Coverage, the Fund will apply the following rules, in order, until an order of benefits is established, unless there is a court order providing otherwise:

(1) The Birthday Rule – The plan that covers the parent whose birthday falls earlier in the calendar year pays first, and the plan that covers the parent whose birthday falls later in the calendar year pays second, if:

(a) The parents are married or living together (regardless of marital status); or

(b) The parents are divorced, separated, or are not living together (regardless of marital status), and there is a court decree that either (a) awards joint custody without specifying that one parent has the responsibility for the Child's health care expenses or coverage or (b) specifically states that both parents are responsible for the Child's health care expenses or coverage.

If both parents have the same birthday, the plan that has covered one of the parents for a longer period of time pays first, and the plan that has covered the other parent for the shorter period of time pays second.

For the purposes of the Fund's COB rules, the word "birthday" refers only to the month and day in a calendar year and does not include the year in which the person was born.

(2) Exception to the Birthday Rule – Court Decree with One Parent Responsible – If the parents are divorced, separated, or are not living together (regardless of marital status), and if the specific terms of a court decree state that only one parent is responsible for the Child's health care expenses or coverage, and the plan of that parent has actual knowledge of the terms of that court decree, then that plan pays first. If, however, the parent with financial responsibility has no coverage for the Child's health care services or expenses, but that parent's current spouse does, the plan of the spouse of the parent with financial responsibility pays first. However, this provision does not apply during any plan year during which any benefits were actually paid or provided before the plan had actual knowledge of the specific terms of that court decree.

(3) Exception to the Birthday Rule – No Court Decree – If the parents are divorced, separated, or are not living together (regardless of marital status), and there is no court decree allocating responsibility for the Child's health care expenses or services, the order of benefit determination among the plans of the parents and their Spouses (if any) is:

(a) The plan of the custodial parent pays first; and

(b) The plan of the Spouse of the custodial parent pays second; and

(c) The plan of the non-custodial parent pays third; and

(d) The plan of the Spouse of the non-custodial parent pays last.

(4) Non-Parental Coverage – For a covered Child who has Other Coverage through an individual who is not the Child's parent (e.g., through the Child's spouse or grandparent), the order of benefits shall be determined by Rule 5 ("Longer/Shorter Length of Coverage"). If, however, the length of coverage is the same, then the Birthday Rule (Rule 2(1)) applies between the Child's coverage under the Fund and the Child's Other Coverage.

Example: *If a married Child covered under this Fund is also covered as a dependent on the group plan of their spouse, the Fund looks to Rule 5 first. If the two plans have the same length of coverage, then the Fund looks to whose birthday is earlier in the calendar year: the Child's parent or the Child's spouse.*

C. Rule 3: Active or Laid-Off/Retired Employee

(1) The plan that covers the Participant either as an active employee (that is, an employee who is neither laid-off nor retired) or as an active employee's dependent pays first, and the plan that covers the same person as a laid-off or retired employee or as a laid-off or retired employee's dependent pays second.

(2) If, however, the Participant is covered as a laid-off or retired employee under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 ("Non-Dependent or Dependent") rather than by this rule.

(3) If the Other Coverage does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

D. Rule 4: Continuation Coverage

(1) If a person whose coverage is provided under a right of continuation under federal or state law (e.g., COBRA coverage) also has Other Coverage or has Dual Coverage, the plan that covers the person as an employee, retiree, member, or subscriber (or as that person's dependent) pays first, and the plan providing continuation coverage to that same person pays second.

(2) If, however, a person is covered as a non-dependent (that is, as an employee, former employee, retiree, member, or subscriber) under a right of continuation coverage under federal or state law under one plan and as a dependent of an active employee under another plan, the order of benefits is determined by Rule 1 ("Non-Dependent or Dependent") rather than by this rule.

(3) If the other plan does not have this rule, and as a result, the plans do not agree on the order of benefits, this rule is ignored.

E. Rule 5: Longer/Shorter Length of Coverage

(1) If none of the four previous rules determines the order of benefits, the plan that has covered the Participant for the longer period of time pays first, and the plan that has covered the same person for the shorter period of time pays second.

(2) To determine how long a Participant has been covered by a plan, two successive plans are treated as one if the Participant became eligible for coverage under the second plan within 24 hours after coverage under the first plan ended.

(3) The start of a new plan does not include a change:

(a) In the amount or scope of a plan's benefits;

(b) In the entity that pays, provides, or administers the plan; or

(c) From one type of plan to another (such as from a single employer plan to a multiple employer plan).

(4) The length of time that a Participant has been covered under a plan is measured from the date he or she was first covered under that plan. If that date is not readily available, the date the Participant first became a member of the group will be used to determine the length of time he or she has been covered under the plan presently in force.

F. Rule 6: When No Rule Determines the Primary Plan

If none of the previous rules determines which plan pays first, each plan will pay an equal share of the allowed expenses incurred by the Participant. For purposes of determining this Fund's share under this Rule 6, "allowed expenses" means this Plan's Allowed Amount(s) for the service(s) provided.

9. Special Rules for Coordination with Prepaid Programs

When a Participant has coverage under the Fund's Indemnity Medical Plan and Other Coverage under a "Prepaid Program" (e.g., an HMO), the Fund will apply these special rules rather than the "Non-Duplication of Benefits" rule (described above in Section 4 of this Chapter) to determine how much it must pay with respect to a Health Claim of the Participant.

For purposes of this rule, the term "Prepaid Program" includes: (i) Health Maintenance Organizations (HMOs), including the Fund's HMO Plans; (ii) Independent Practice Associations; (iii) Exclusive Provider Organizations; (iv) and such other programs that the Board of Trustees, in its sole discretion, deem to be essentially similar to such prepaid arrangements.

Coordination with Prepaid Programs

If a Participant has coverage under the Fund's Indemnity Medical Plan (the "Plan") and Other Coverage under a Prepaid plan or program, the Fund will apply non-duplication of benefits, and the Fund's payment will be determined as follows:

(1) <u>If the Plan Is Primary</u>

When the Plan is primary to the Other Coverage, the Fund will pay its Normal Benefit as if no Other Coverage was involved.

(2) If the HMO (or Prepaid Plan) Coverage is Primary

When the Plan is secondary to the Other Coverage (i.e., the Other Coverage is primary), then benefits will be determined as follows:

(a) If the amount paid by the Other Coverage is less than the Normal Benefit provided under the Plan, then the Fund will pay the difference between its Normal Benefit and the amount paid by the Other Coverage.

(b) If the amount paid by the Other Coverage is the same as or greater than the Normal Benefit provided under the Plan, then the Fund will not pay any benefits.

In determining the amount of the Plan's Normal Benefit for this purpose, the Plan's Allowed Amount will not exceed the charge allowed by the Other Coverage.

(3) Notwithstanding paragraph (2), if the primary Fund Plan is a Fund HMO Plan, the Fund will not reimburse the Participant if he or she uses the Indemnity Medical Plan as the Dependent of another Enrollee.

10. Administration of COB

A. Participants are required to notify the Fund Office of any Other Coverage that they have.

B. To administer these COB rules, the Fund reserves the right to:

(1) Exchange information regarding a Participant's Health Claim(s) with the Other Coverage;

(2) Require that a Participant or his/her Health Care Provider furnish any necessary information regarding the Participant's Other Coverage and/or Health Claim(s) to the Fund;

(3) Reimburse a Participant or his/her Other Coverage that made payments that the Fund should have made; and

(4) Recover any overpayment from a Participant's Hospital, Physician, Dentist, other Health Care Provider, other insurance company or health plan, the Participant, or any other person or entity to, or for, whom the Fund paid excess benefits.

C. If the Fund should have paid benefits that were paid by any other plan, the Fund may pay the party that made the other payments in the amount the Plan Administrator or its designee determines to be proper under this provision. Any amounts so paid will be considered benefits paid under this Plan, and the Fund will be fully discharged from any liability it may have to the extent of such payment.

D. To obtain all available benefits, a Participant should file a claim under each plan that covers the Participant for the expenses that were incurred. However, any Participant who claims benefits under this Plan must provide all the information the Fund needs to apply these COB rules.

E. This Fund will not pay expenses for which a Participant has no liability.

F. If the Indemnity Medical Plan is secondary, and if the Other Coverage is also secondary because it provides by its terms that it is always secondary or excess to any other coverage, or because it does

not use the same order of benefit determination rules as this Plan, this Plan will not relinquish its secondary position. However, if the Fund advances an amount equal to the benefits it would have paid had this Plan been the primary plan, this Plan will be subrogated to all rights the Participant may have against the Other Coverage, and the Participant must execute any documents required or requested by the Fund to pursue any claims against the Other Coverage for reimbursement of the amount advanced by the Fund.

11. Coordination of Benefits with Medicare

A. General Rules

(1) If a Participant has Medicare coverage, the Fund will apply the following Medicare Secondary Payer ("MSP") rules to determine whether Medicare is primary to the Plan instead of the "Order of Benefit Determination Rules" described above in Section 8 of this Chapter, above.

(2) If a Participant has Other Coverage in addition to Medicare, the Fund will first apply these MSP rules to determine whether Medicare is primary or secondary to the Plan, and then it will apply the "Order of Benefit Determination Rules" in Section 8 of this Chapter, above, to determine the order of benefits between this Plan and the Other Coverage.

B. Medicare Beneficiaries May Retain or Cancel Coverage Under This Fund

If a Participant becomes covered by Medicare, whether because of age, disability, or end-stage renal disease (ESRD), the Participant may either retain or cancel his or her Fund coverage.

*If any of your covered Dependents has Medicare, and you **cancel** that Dependent's coverage under this Fund (for instance, the Dependent is dropped from coverage at Open Enrollment time), that Dependent will **not** be entitled to COBRA Coverage, since being dropped at Open Enrollment is not a COBRA Qualifying Event.*

The choice of retaining or canceling Fund coverage of a Medicare beneficiary is solely your responsibility. Neither the Fund nor your Employer will provide any consideration, incentive, or benefits to encourage cancellation of coverage under this Fund.

C. Age-Based or Disability-Based Medicare Entitlement

For a Participant whose entitlement to Medicare is based on age or disability:

(1) If the Participant has Fund coverage due to an Employee's current employment status (i.e., the Participant is covered under the Gold, Platinum, or Platinum Plus Plan), this Plan is primary to Medicare.

(2) If, however, the Participant has Retiree Health Plan or COBRA coverage under the Fund, Medicare is primary to that plan.

D. Medicare Entitlement Based on End-Stage Renal Disease

For a Participant whose eligibility or entitlement to Medicare is based on end-stage renal disease (ESRD), regardless of whether he or she has active, retiree, or COBRA Coverage under the Fund:

(1) This Plan is primary to Medicare for the first 30 months of ESRD-based Medicare eligibility or entitlement.

EXCEPTION: If the Participant is already entitled to Medicare on the basis of age or disability when (s)he becomes eligible for Medicare on the basis of ESRD, and Medicare is primary to this Plan at that time because Fund coverage was not by virtue of current employment status, Medicare will remain primary.

(2) Then, starting with the 31st month after the start of ESRD-based Medicare eligibility or entitlement, Medicare is primary to this Plan.

An individual is eligible for ESRD-based Medicare on the earlier of: (i) the first month in which the individual becomes entitled to Medicare Part A on the basis of ESRD; or (ii) the first month the individual would have become entitled to (i.e., enrolled in) Medicare part A on the basis of ESRD if (s)he had enrolled in such coverage.

E. How Much the Fund Pays When this Plan Is Secondary to Medicare

(1) When a Participant is also covered by Medicare Parts A and/or B

When a Participant is also covered by Medicare Parts A and/or B, and this Plan is secondary to Medicare, the Fund will apply non-duplication and will pays its regular benefits (i.e., the same benefits provided under this Plan for active Employees), less any amounts paid or owed by Medicare. In determining the amount of the Plan's regular benefits for this purpose, the Fund uses the fees allowed by Medicare (i.e., Medicare's allowed amounts) and does not use the billed charges of the Health Care Provider. If the amount paid by Medicare is the same as or greater than the Plan's regular benefits, then the Fund will not pay any benefits. If the Provider does not accept Medicare, then the Fund will not pay any benefits.

(2) When a Participant is also covered by a Medicare Advantage Program without Prescription Drug benefits

If a Participant is also covered by a Medicare Advantage program, and this Plan is secondary to Medicare, when the Participant obtains medical services or supplies in compliance with the rules of that program, including, without limitation, obtaining all services In-Network when the Medicare Advantage program requires it, this Plan will coordinate as the secondary payer based on non-duplication of benefits. In determining the amount of the Fund's regular benefits for this purpose, the Fund uses the fees allowed by the Medicare Advantage Program as its Allowed Amount.

On the other hand, if the Participant does not comply with the rules of their Medicare Advantage program, including without limitation, approved referral, Precertification, Case Management, or utilization of Network Provider requirements, the Fund will NOT provide any health care services or supplies or pay any benefits for any services or supplies that the Participant receives.

(3) When a Participant also enters into a Medicare Private Contract

If this Plan is secondary to Medicare, and a Participant who is enrolled in Medicare enters into a Medicare Private Contract with a Health Care Provider (who has opted out of Medicare) under which no claim will be submitted to or paid by Medicare for health care services or supplies furnished by that Health Care Provider, the Fund will NOT pay any benefits for any health care services and/or supplies the Participant receives pursuant to the Medicare Private Contract.

(4) When a Participant is also covered by a Medicare Part D Prescription Drug Plan

If a Participant is also covered by Medicare Part D, and this Plan is secondary to Medicare, this Plan will coordinate as the secondary payer based on non-duplication of benefits. For more information on Medicare Part D, refer to www.medicare.gov or contact the Fund Office.

12. Coordination with Government and Other Programs

If a Participant has Other Coverage under one or more of the government or other programs listed below, the Fund will apply the rules in this section, rather than the "Order of Benefit Determination Rules" (described above in Section 8 of this Chapter), to determine whether this Plan is primary (i.e., pays first) or secondary (i.e., pays second).

A. **Medicaid.** If a Participant is covered by Medicaid or a State Children's Health Insurance Program ("CHIP"), this Plan pays first, and Medicaid or CHIP pays second.

B. **TRICARE.** If a Participant is covered by TRICARE, this Plan pays first, and TRICARE pays second, unless the individual is an active duty service member. For individuals who are active duty service members, TRICARE is primary, and this Plan is secondary.

C. **Veterans Affairs/Military Medical Facility Services.** If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of a military service-related Illness or Injury, benefits are not payable by the Fund. If a Participant receives services in a U.S. Department of Veterans Affairs Hospital or other military medical facility on account of any other condition that is **not** a military service-related Illness or Injury, benefits are payable by the Fund to the extent those services are Medically Necessary and covered under the Plan, unless the individual has TRICARE as an active duty service member, in which case TRICARE will be primary.

D. **Motor Vehicle Coverage.** The Fund does not coordinate benefits with motor vehicle coverage.

E. **Indian Health Services.** If a Participant is covered by Indian Health Services, this Plan pays first, and Indian Health Services pays second.

F. **Other Coverage Provided by State or Federal Law.** If a Participant has Other Coverage (not already mentioned previously) that is provided by any other state or federal law, such Other Coverage pays first, and this Plan pays second.

XIII
COBRA & USERRA:
TEMPORARY CONTINUATION OF HEALTH COVERAGE

In this Chapter, the terms "you" and "your" refer to the Employee.

1. Entitlement to COBRA Continuation Coverage

In compliance with a federal law called the Consolidated Omnibus Budget Reconciliation Act of 1985 (commonly called "COBRA"), you and your covered Spouse and Children (called "Qualified Beneficiaries") will have the opportunity to elect a temporary continuation of your group health coverage under the Fund (called "COBRA Coverage") when that coverage would otherwise end because of certain events (called "Qualifying Events"), provided that proper notice of such Qualifying Event is provided to the Fund Office in a timely manner. Qualified Beneficiaries who elect COBRA Coverage must pay for it at their own expense.

2. Alternatives to COBRA Coverage

You may have health coverage alternatives to COBRA Coverage available to you that can be purchased through the Health Insurance Marketplace (in California, Covered California). In the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace coverage right away, and you can see what your premium, deductibles, and out-of-pocket costs will be before you make a decision to enroll. Being eligible for COBRA Coverage does not limit your eligibility for coverage or for a tax credit through the Marketplace. For more information about the Health Insurance Marketplace, visit www.healthcare.gov.

Also, you may qualify for a special enrollment opportunity in another group health plan for which you are eligible (such as your Spouse's plan) if you promptly request enrollment in that plan (usually within 30 days after your Fund coverage ends), even if that plan generally does not accept late enrollees. This special enrollment right may also be available to you after the expiration of the maximum COBRA Coverage period available to you.

3. Who Is Entitled to COBRA Coverage, When, and for How Long?

A. Qualified Beneficiaries

Only Qualified Beneficiaries are entitled to COBRA Coverage. A Qualified Beneficiary is an Employee, or the Spouse or Child of an Employee, who loses Fund coverage due to the occurrence of a Qualifying Event. A Child who becomes an Employee's Dependent by birth, adoption, or placement for adoption while the Employee is receiving COBRA Coverage is also a Qualified Beneficiary.

Domestic Partners are **not** Qualified Beneficiaries and are not eligible for COBRA Coverage.

A Child of the covered Employee, who is receiving benefits under the Fund because of a Qualified Medical Child Support Order (QMCSO) during the Employee's period of employment, is entitled to the same rights under COBRA as any other covered Child.

A person who becomes the new spouse of a COBRA enrollee may be added to the enrollee's COBRA

Coverage, but the new spouse will not be a "Qualified Beneficiary." This means that if the COBRA enrollee dies or divorces before the expiration of the maximum COBRA Coverage period, the new spouse is not entitled to elect COBRA Coverage for him/herself.

B. Qualifying Events

A life event is a "Qualifying Event" triggering the opportunity to elect COBRA Coverage only if the Participant **LOSES** health care coverage under the Fund as a result of that event. If a Participant experiences one of the events shown below but **does not lose** health care coverage under the Fund as a result of that event (e.g., the Employee continues working even though entitled to Medicare), then there is no Qualifying Event, and COBRA Coverage is not available.

The following chart lists the COBRA Qualifying Events and shows who can be a Qualified Beneficiary and the maximum period of COBRA Coverage available (the "maximum COBRA Coverage period") based on that Qualifying Event:

Qualifying Events (must cause loss of health care coverage under the Fund)	**Duration of COBRA for Qualified Beneficiaries**		
	Employee	**Spouse**	**Child(ren)**
Employee terminated (other than for gross misconduct)	18 months	18 months	18 months
Employee reduction in hours worked (making Employee ineligible for coverage)	18 months	18 months	18 months
Employee dies	N/A	36 months	36 months
Employee becomes divorced	N/A	36 months	36 months
Child ceases to have Dependent status	N/A	N/A	36 months

C. Maximum COBRA Coverage Period

The maximum COBRA Coverage period is generally either 18 or 36 months, depending on the Qualifying Event, measured from the first day of the month following the month in which the Qualifying Event occurred. For reduction in hours, the Qualifying Event date is the last day of the Work Month in which hours worked are sufficient to provide continuing eligibility.

For example: *If the Qualifying Event occurred on January 5, 2025, then COBRA Coverage would begin on February 1, 2025, regardless of when Fund coverage actually ends.*

(1) Extended Active Coverage. The maximum COBRA Coverage period includes months of extended active coverage provided by the Fund after the Qualifying Event date due to: (a) the normal run-off of eligibility following a reduction in hours of employment; (b) self-payment; (c) receiving Extended Coverage while you are disabled, unemployed, or on Workers' Compensation; (d) the hospitalization and maternity extensions described in Section 6.C of the "Eligibility Rules" Chapter of this booklet; and/or (e) the normal run-off of eligibility following retirement, if you are in the Gold Plan. The requirement to pay premiums for COBRA coverage, however, will not begin until **after** this extended active coverage period has been exhausted.

(2) Extension of COBRA Coverage. An 18-month period of COBRA Coverage may be extended under certain circumstances when there is a second Qualifying Event or disability, as described in Section 11 ("Extension of the 18-Month Maximum COBRA Coverage Period") of this Chapter, below.

(3) Employee's Medicare Entitlement Before Termination or Reduction in Hours of Employment. If a Qualifying Event that is the termination or reduction in hours of employment occurs within 18 months after the Employee has enrolled in Medicare, the maximum COBRA Coverage period for the Employee's Dependents who are Qualified Beneficiaries (but not the Employee) is 36 months, beginning on the Employee's Medicare entitlement date.

(4) Early Termination of COBRA Coverage. The maximum COBRA Coverage period may be cut short for the reasons described in Section 12 ("Early Termination of COBRA Coverage") of this Chapter, below.

4. Initial COBRA Notice

A notice of COBRA Coverage rights ("Initial COBRA Notice") will be provided to you and your Spouse within 90 days after the date your and your Spouse's Fund coverage commences, unless: (i) a Qualifying Event occurs within this 90-day period, and a timely COBRA Election Notice is furnished; or (ii) a Summary Plan Description is distributed within this 90-day period. A single Initial COBRA Notice may be addressed to both you and your Spouse, if the most recent information available to the Fund shows that you reside together, and your Spouse's coverage began within 90 days after your coverage commenced.

5. You Must Notify the Fund Office of Certain Qualifying Events

Qualified Beneficiaries will be entitled to elect COBRA Coverage only after proper notice of a Qualifying Event has been provided to the Fund Office in a timely manner.

When the Qualifying Event is divorce or a Child losing status as a Dependent as defined by the Fund, **you and/or a family member must inform the Fund Office in writing of the event no later than 60 days after the last day of the month in which the Qualifying Event occurred.**

The written notice must be sent to the Fund Office via first class mail or hand-delivery and must include (i) your name, (ii) the name(s) of your Dependent(s), if applicable, (iii) your mailing address and telephone number, (iv) the mailing address(es) and telephone number(s) of your Dependent(s), if different, (v) the Qualifying Event, (vi) the date of the Qualifying Event, and (vii) appropriate documentation in support of the Qualifying Event, such as divorce documents.

A timely notice that does not contain all of the information listed above is considered valid if (i) it contains sufficient information for the Fund Office to determine the group health plan, the covered Employee and Qualified Beneficiary(ies), the Qualifying Event, and the date on which the Qualifying Event occurred, and (ii) the individual provides additional information requested by the Fund Office within a reasonable period of time, not to exceed 30 days.

NOTE: If notice of a Qualifying Event is not received by the Fund Office within 60 days of the last day of the month in which the Qualifying Event happened, the Qualified Beneficiary will not be entitled to elect COBRA Coverage.

An Employee or Dependent who fails to notify the Fund Office of a divorce or cessation of Dependent Child status will be responsible for reimbursing the Fund for any medical expenses or premiums paid by the Fund to or on behalf of the Dependent who received benefits or coverage to which he or she was not entitled due to the loss of eligibility. The Fund may pursue recovery by legal action against the Employee, Dependent, or third-party Provider who received the overpayment or may reduce future benefits payable to or on behalf of the Employee and any of the Employee's eligible Dependents until the total amount of the overpayment has been recovered.

Your Employer is responsible for notifying the Fund Office of your death or of the termination or reduction in hours of your employment. However, **you or your family should also promptly notify the Fund Office, preferably in writing, if any such event occurs** to avoid confusion over the status of your health care in the event there is a delay or oversight in receiving notification from your Employer.

6. How to Elect COBRA Coverage

When:

- **Your Employer notifies the Fund Office** that your employment has terminated, your hours have been reduced, or you have died; or
- **You timely notify the Fund Office** that you have divorced or a Child has lost Dependent Child status (e.g., because the Child has reached age 26);

and the Fund Office determines that you and/or your Dependents will lose Fund coverage as a result of such event, **then** the Fund Office will provide you and/or your covered Dependents a COBRA election notice containing the information and forms needed to elect COBRA Coverage.

If you fail to timely notify the Fund Office that that you have divorced or that a Child has lost Dependent Child status, you and/or your Dependent(s) will lose the right to elect COBRA Coverage.

The COBRA election notice and forms will be provided within 45 days after the date Fund coverage is lost due to the Qualifying Event. The COBRA election notice may be provided to: (i) you and your Spouse by sending a single notice addressed to both if the most recent information available to the Fund shows that you reside together; and/or (ii) your Child by sending a single notice to you or your Spouse, if the most recent information available to the Fund shows that the Child resides with the addressee.

You and/or your covered Dependents will then have 60 days after the later of (i) the date of the COBRA election notice, or (ii) the date Fund coverage ends due to the Qualifying Event, to elect COBRA Coverage by mailing the COBRA election form to the Fund Office. A COBRA election is considered made on the date the completed and signed COBRA election form is postmarked or hand-delivered to the Fund Office or a Union Local Insurance Office.

Note: Each Qualified Beneficiary **has an independent right to elect COBRA** Coverage. For example, your Spouse may elect COBRA Coverage even if you do not. COBRA Coverage may be elected for only one, some, or for all Dependents who are Qualified Beneficiaries. Furthermore, you may elect COBRA Coverage on behalf of your Spouse, and covered parents/legal guardians may elect COBRA Coverage for a minor Child.

If a Qualified Beneficiary rejects COBRA Coverage before the end of the 60-day election period, the Qualified Beneficiary may change his/her mind as long as a completed COBRA election form is submitted to the Fund Office before the end of the 60-day period. If this occurs, COBRA Coverage will begin on the date the completed and signed COBRA election form is submitted.

7. The COBRA Coverage That Will Be Provided

If you elect COBRA Coverage, you will continue in the same health plan option that you had before the occurrence of the Qualifying Event that caused your health coverage under the Fund to end.

Each Qualified Beneficiary electing COBRA Coverage may choose from the following two coverage options:

- "COBRA Core-Only" Benefits: Medical and Prescription Drug coverage only.
- "COBRA Core-Plus" Benefits: Medical, Prescription Drug, dental, and vision coverage.

COBRA coverage does not include coverage for Death Benefits or other Fund benefits not listed above.

Each Qualified Beneficiary has an independent right to select a coverage option (e.g., you need not elect the same coverage option chosen by your Spouse). Once you have made your election for either the COBRA Core-Only or COBRA Core-Plus coverage option, you may not change it.

You will remain in the plan of benefits (e.g., the Indemnity Medical Plan vs. HMO Plan) that you had prior to the Qualifying Event that made you eligible for COBRA Coverage, with certain exceptions. For example, if you are enrolled in an HMO Plan, you may not enroll in the Indemnity Medical Plan when you apply for COBRA Coverage, except in the following situations: (i) during an Open Enrollment period; or (ii) if you are moving outside the HMO Plan's service area.

Once you have elected COBRA Coverage, if there is a change in the health coverage provided by the Fund to similarly-situated active Employees and their families, that same change will apply to your COBRA Coverage. A Qualified Beneficiary who elects COBRA Coverage also has the same rights and enrollment opportunities under the Fund as other covered individuals, including Open Enrollment and Special Enrollment rights. For example, you may change medical plans if eligible (e.g., Indemnity to HMO) during the Fund's annual Open Enrollment period.

8. Paying for COBRA Coverage (The Cost of COBRA)

Any person who elects COBRA Coverage must pay for it. The Fund may charge up to 102% (or 150% in the case of an extension of COBRA Coverage due to a disability) of the full cost of coverage for similarly-situated active Employees and their families.

The COBRA election notice will contain premium rate information for COBRA Coverage. After your first COBRA payment, you must make monthly COBRA payments. You are responsible for making timely payments for COBRA Coverage. Invoices (bills) for COBRA premium payments will **not** be provided.

The cost of COBRA Coverage may be subject to future increases. Once every 12 months, new COBRA premiums may be established by the Board of Trustees. COBRA premiums may be changed more frequently for all COBRA enrollees, however, if there is a change in the cost for benefits provided to similarly-situated Fund Participants who are not receiving COBRA coverage or if the law requires or permits a COBRA premium change. In these cases, the new COBRA premium will be effective for a 12-month period, unless further changes in the law affect the COBRA premium. COBRA enrollees will be advised in advance of any COBRA premium adjustments.

A. Initial COBRA Payment

The **initial payment** for COBRA Coverage is due **no later than 45 days** after COBRA Coverage is elected

(i.e., the date the COBRA election form is postmarked or hand-delivered to the Fund Office). The initial payment is considered made on the date that it is postmarked or hand-delivered to the Fund Office or a Union Local Insurance Office.

This initial payment must be sufficient to cover the COBRA premiums due from the date Fund coverage terminated through the last day of the calendar month ending immediately before the date the initial payment is made. You may contact the Fund Office to obtain the amount of the initial payment. If this payment is not made when due, COBRA Coverage will not take effect. Once a timely COBRA election form and the initial COBRA payment is received, claims incurred during the COBRA election period will be processed in accordance with Plan terms, and Qualified Beneficiaries will be reimbursed for covered out-of-pocket expenses incurred during the COBRA election period.

B. Monthly COBRA Payments and Grace Periods

After the initial COBRA premium payment, subsequent monthly payments for COBRA Coverage are due on the first day of each month, but there is a 30-day grace period to make those payments. If payments are not made within this 30-day grace period, COBRA Coverage will be terminated as of the due date.

Payment is considered made on the date that it is postmarked or hand-delivered to the Fund Office or a Union Local Insurance Office.

If a monthly COBRA payment is made after the first day of the month to which it applies, but before the end of the grace period for the month, COBRA Coverage will be suspended as of the first day of the month and then retroactively reinstated (going back to the first day of the month) when the monthly payment is received. Any Claim submitted for benefits while COBRA Coverage is suspended may be denied and may have to be resubmitted once coverage is reinstated.

C. Confirmation of Coverage before Election or Payment

A Health Care Provider may contact the Fund Office to request confirmation of the coverage of a Qualified Beneficiary who either (i) has elected COBRA but has not yet paid the amount required for COBRA Coverage before the end of the grace period **or** (ii) is within the COBRA election period but has not yet elected COBRA. In these situations, the Fund Office will inform the Health Care Provider that:

- Either (i) COBRA was elected but the cost of the COBRA Coverage has not been paid or (ii) COBRA has not been elected but the COBRA election period has not yet expired;
- No Claims will be paid until the amounts due have been received; and
- Either (i) COBRA Coverage will terminate effective as of the due date of any unpaid amount if payment of the amount due is not received by the end of the grace period or (ii) Fund coverage will terminate if COBRA is not elected by the end of the COBRA election period.

D. Deficiencies

An individual who submits a timely good faith COBRA payment that is deficient by an amount that is not significant will be notified of the deficiency and allowed 30 days from the date of the notice to pay the deficiency. A deficiency is not significant if the amount of the deficiency is no greater than the lesser of $50 (as adjusted by the IRS) or 10% of the amount required to be paid. Collection of deficiencies of amounts less than $5 may be waived.

E. 90-Day and Final Payment Notices

While not legally required, the Fund Office may notify you when 90 days of your maximum COBRA Coverage period remain and also when payment for the final month of COBRA Coverage has been received. These notices may be provided to: (i) you and your Spouse by sending a single notice addressed to both if the most recent information available to the Fund shows that you reside together; and (ii) your Child by sending a single notice to you or your Spouse, if the most recent information available to the Fund shows that the Child resides with the addressee.

9. Adding Dependents to COBRA Coverage

A Qualified Beneficiary receiving COBRA Coverage may add his/her spouse and/or child to his/her COBRA Coverage for the balance of his/her maximum COBRA Coverage period in accordance with the Fund's Open Enrollment and Special Enrollment rules, provided that any additional COBRA premium required to cover such individuals is paid. A newly added spouse or child will not be considered a Qualified Beneficiary with independent COBRA rights, unless such Dependent is a Child born to, adopted by, or placed for adoption with an Employee while the Employee is receiving COBRA Coverage.

10. Notice of Unavailability of COBRA Coverage

If the Fund Office is notified of a Qualifying Event or disability determination regarding an Employee, Dependent, or other person, but determines that such person is not entitled to the requested COBRA Coverage (or extension of COBRA Coverage), then the Fund Office will send the individual a written explanation indicating why COBRA Coverage (or extension of COBRA Coverage) is not available. This notice of the unavailability of COBRA Coverage will be sent within 45 days of receiving such request. This notice may be provided to: (i) the Employee and his/her Spouse by sending a single notice addressed to both if the most recent information available to the Fund shows that they reside together; and (2) a Dependent who is the Child of the Employee by sending a single notice to the Employee or his/her Spouse, if the most recent information available to the Fund Office shows that the Child resides with the addressee.

11. Extension of the 18-Month Maximum COBRA Coverage Period

A. Extension Due to a Second Qualifying Event

If, during an 18-month maximum COBRA Coverage period resulting from loss of coverage because of your termination of employment or reduction in hours, a second Qualifying Event occurs that is your death, divorce, or the cessation of Dependent Child status under the Fund, the original 18-month maximum COBRA Coverage period will be extended to 36 months for any individual who (i) was your Dependent on the first Qualifying Event date and (ii) had COBRA Coverage as of the second Qualifying Event date, but only if the second Qualifying Event would have caused your Dependent to lose Fund coverage had the first Qualifying Event not occurred.

NOTE: Medicare entitlement cannot be a second Qualifying Event.

(1) Notifying the Fund – To extend COBRA Coverage when a second Qualifying Event occurs, you or your Dependent must notify the Fund Office in writing within 60 days of the date of the second Qualifying Event. **You will lose your right to extended COBRA Coverage if you do not notify the Fund within this 60-day period.**

The written notice must be sent via first class mail or be hand-delivered to the Fund Office and must include (i) your name, (ii) the name(s) of your Dependent(s), (iii) your mailing address and telephone number, (iv) the mailing address(es) and telephone number(s) of your Dependent(s), if different, (v) the second Qualifying Event, (vi) the date of the second Qualifying Event, and (vii) appropriate documentation in support of the second Qualifying Event, such as divorce documents.

A timely notice that does not contain all of the information listed above is considered valid if: (i) it contains sufficient information for the Fund Office to determine the group health plan, the covered Employee and Qualified Beneficiary(ies), the second Qualifying Event, and the date on which the second Qualifying Event occurred; and (ii) the individual provides additional information requested by the Fund Office within a reasonable period of time, not to exceed 30 days.

(2) **This extension of COBRA Coverage is <u>not</u> available to anyone who became your Spouse after your termination of employment or reduction in hours**. This extended period of COBRA Coverage is, however, available to any Child(ren) born to, adopted by, or placed for adoption with you (the covered Employee) during your 18-month maximum COBRA Coverage period.

(3) In no case is an Employee whose employment terminated or who had a reduction in hours entitled to COBRA Coverage for more than a total of 18 months (unless the Employee is entitled to an additional period of up to 11 months of COBRA Coverage on account of disability as described in the following Subsection B). For example, if you experience a reduction in hours followed by termination of employment, the termination of employment is not treated as a second Qualifying Event, and COBRA Coverage may not be extended beyond 18 months from the initial Qualifying Event.

(4) In no case is anyone entitled to COBRA Coverage for more than a total of 36 months.

B. Extension Due to Disability

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Coverage, the Social Security Administration (SSA) makes a formal determination that you or your covered Spouse or Child is totally and permanently disabled so as to be entitled to Social Security Disability Income benefits (SSDI), the disabled person and any covered family members who so choose may be entitled to keep COBRA Coverage for up to 29 months (instead of 18 months) or until the disabled person becomes entitled to Medicare or ceases to be disabled (whichever is sooner).

This extension is available only if:

- The SSA determines that the individual's disability began at some time before the 60th day of COBRA Coverage;
- The disability lasts until at least the end of the 18-month period of COBRA Coverage; **and**
- The Fund Office is timely notified of the individual's disability.

(1) <u>Notifying the Fund Office</u> – You (or another family member) must notify the Fund Office by sending written notice of the SSA's determination within 60 days after the later of (i) the date of the SSA determination or (ii) the date Fund coverage is lost as a result of the termination or reduction in hours of employment. In any event, notice must be provided before the end of the initial 18-month COBRA Coverage period. **You will lose your right to extended COBRA Coverage if you fail to notify the Fund Office within this 60-day period.**

The written notice can be sent via first class mail, or be hand-delivered, and must include (i) your name, (ii) the name(s) of your Dependent(s), (iii) your mailing address and telephone number, (iv) the mailing address(es) and telephone number(s) of your Dependent(s), if different, (v) the name of the disabled person, (vi) a statement that the notice is a request for an extension of COBRA due to a disability, (vii) the date the disability began, and (viii) appropriate documentation in support of the disability, including a copy of the written SSA disability award documentation.

A timely notice that does not contain all of the information listed above is considered valid if: (i) it contains sufficient information for the Fund Office to determine the group health plan, the covered Employee and Qualified Beneficiary(ies), the disability, and the date on which the disability occurred; and (ii) the individual provides additional information requested by the Fund Office within a reasonable period of time, not to exceed 30 days.

(2) Increased Cost – The cost of COBRA Coverage during the additional 11-month period may be up to 150% of the full cost of coverage for similarly-situated active Employees and their families (i.e., substantially more than the cost for COBRA Coverage during the initial 18-month period).

(3) Termination – The disability extension will terminate on the first day of the month that begins at least 30 days after the date of the SSA's final determination that you or your Spouse or Child is no longer disabled. The Fund Office must be notified within 30 days of the determination by the SSA that an individual is no longer disabled.

12. Early Termination of COBRA Coverage

A. Early Termination Events

Once COBRA Coverage has been elected, it may be cut short (i.e., terminated before the end of your maximum COBRA Coverage period) on the occurrence of any of the following events:

(1) Any amount due for COBRA coverage is not paid in full on time.

(2) The Qualified Beneficiary becomes entitled to Medicare (Part A, Part B, or both) after electing COBRA Coverage. ***NOTE: The Qualified Beneficiary must notify the Fund Office of such event within 30 days of the Medicare entitlement date.***

(3) The Qualified Beneficiary becomes covered under another group health plan. ***IMPORTANT: The Qualified Beneficiary must notify the Fund Office as soon as possible once they become aware that they will become covered under another group health plan.*** COBRA Coverage under this Fund ends on the date the Qualified Beneficiary is first covered under the other group health plan.

(4) During an extension of the maximum COBRA Coverage period for up to 29 months due to the disability of the Qualified Beneficiary, the Qualified Beneficiary is determined by the SSA to no longer be disabled. ***NOTE: The Qualified Beneficiary must notify the Fund Office of such event within 30 days of the SSA determination date.***

(5) The Fund Office determines that the Qualified Beneficiary's COBRA Coverage must be terminated for cause (on the same basis as would apply to similarly-situated non-COBRA participants under the Fund).

(6) The Fund no longer provides group health coverage.

(7) Your Employer stops making contributions to this Fund on behalf of its Active Employees and provides alternative group health coverage to those Employees under another plan.

B. Notice of Early Termination of COBRA Coverage

The Fund Office will notify a Qualified Beneficiary if his or her COBRA Coverage terminates before the end of the applicable maximum COBRA Coverage period. This written notice will explain the reason for terminating COBRA Coverage early, the date COBRA Coverage terminated, and any rights the Qualified Beneficiary may have under the Fund to alternate or conversion coverage, if applicable. The notice will be provided as soon as practicable after the Fund Office determines that COBRA Coverage will terminate early. This notice may be provided to: (1) you and your Spouse by sending a single notice addressed to both if the most recent information available to the Fund shows that you reside together; and (2) your Child by sending a single notice to your or your Spouse, if the most recent information available to the Fund shows that the Child resides with the addressee.

C. Claims Incurred and COBRA Premiums Paid Following the Termination of COBRA

(1) Claims Incurred – If the Fund pays for any claims incurred by a Qualified Beneficiary after his/her COBRA Coverage termination date, the Qualified Beneficiary must reimburse the Fund for the claims paid.

(2) COBRA Premium Payments – If a Qualified Beneficiary pays for any COBRA Coverage period(s) after his/her COBRA Coverage termination date, such COBRA premium payment(s) will be refunded to the Qualified Beneficiary, but only after the Fund has received any required reimbursements for claims paid from the Qualified Beneficiary, if applicable.

13. Converting to an Individual Health Plan after COBRA Coverage Ends (for HMO Enrollees Only)

If you have coverage under one of the Fund's HMO Plans, you may be eligible to convert to an individual plan provided by your HMO upon the exhaustion of your maximum COBRA Coverage period.

There is no opportunity to convert to an individual health plan after COBRA Coverage ends under the Indemnity Medical Plan or the Indemnity Dental Plan.

14. Cal-COBRA Coverage (for HMO Medical Benefits Only)

A COBRA Qualified Beneficiary who is enrolled in an HMO Plan and who has exhausted his or her maximum COBRA Coverage period of less than 36 months may be entitled to continue Fund coverage under California law (Cal-COBRA), up to a total of 36 months of coverage from the date federal COBRA coverage started. For more information on or to enroll in Cal-COBRA, contact your HMO directly.

15. How FMLA Interacts with COBRA

Taking a leave under the Family & Medical Leave Act (FMLA) is not a COBRA Qualifying Event. (A reduction in hours that causes a loss of coverage is, however, a Qualifying Event. Similarly, a Qualifying Event could occur after the FMLA period expires, for example, if you do not return to work and thus lose Fund coverage.)

16. COBRA Questions or to Give Notice of Changes in Your Circumstances

If you have any questions about your COBRA rights, please contact the Fund Office.

Also, remember that to avoid loss of any of your rights to obtain or continue COBRA Coverage, you or a family member must notify the Fund Office:

- Within 60 days of a divorce.
- Within 60 days of a second Qualifying Event that is the Employee's death, divorce, or loss of Dependent Child status.
- Within 60 days of the date you or a covered Spouse or Child has been determined to be totally and permanently disabled by the Social Security Administration.
- Within 60 days of the date a covered Child ceases to be a "Dependent Child."
- Promptly if an individual has changed their address, becomes entitled to Medicare, or is no longer disabled.

IMPORTANT REMINDER: If you get divorced, you must notify the Fund Office immediately.

If you have not notified the Fund Office of your divorce, you will be required to reimburse the Fund for any benefits paid or expenses incurred in providing coverage to your ineligible family members (e.g., your former spouse and stepchildren).

In addition, if the Fund Office is not timely notified of your divorce, your former spouse (and any stepchildren) will lose the right to elect COBRA Coverage.

17. Leave for Military Service: Uniformed Services Employment and Reemployment Rights Act (USERRA)

A covered Employee who enters military service (and his or her covered Dependents, if any) will be provided continuation and reinstatement rights in accordance with the requirements of the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. This section contains important information about the right to continuation coverage and reinstatement of coverage under USERRA.

A. What is USERRA Continuation Coverage?

USERRA Continuation Coverage ("USERRA Coverage") is a temporary continuation of Fund coverage when it would otherwise end because you are absent from work due to "service in the uniformed services," as defined under USERRA.

"Uniformed services" includes the Armed Forces, the Army National Guard, and the Air National Guard when an individual is engaged in active duty for training, inactive duty training, or full-time National Guard duty, National Disaster Medical Service, the commissioned corps of the Public Health Service, and any other category of persons designated by the President in time of war or national emergency.

Fund coverage for you (and your covered Dependents, if any) will terminate at the end of the month in which your military leave begins.

As required by USERRA, you may elect to continue Fund coverage for yourself, as well as for your Dependents who were covered under the Fund on the day your leave started, for up to 24 months, measured from the date you stopped working. If you are absent from work for more than 30 days, you must pay the monthly premium for USERRA Coverage. If your absence from work is for less than 31 days, you need only pay your regular monthly contribution to premium based on your family size.

B. Duty to Notify the Fund Office

The Fund will offer USERRA Coverage only after you have notified the Fund Office in writing of your military leave, and you provide a copy of your orders. This notice must be provided as soon as possible, but no later than 60 days after the date on which your Fund coverage will terminate due to your military leave, unless it is impossible or unreasonable to give such notice.

C. Offer of USERRA Coverage

Once the Fund Office receives timely notice of your military leave, it will offer you the right to elect USERRA Coverage for yourself, as well as for any of your Dependents who were covered under the Fund on the day your leave started. Unlike COBRA Coverage, if you do not elect USERRA Coverage for yourself and your covered Dependents, those Dependents cannot separately elect USERRA Coverage for themselves.

USERRA Coverage is an alternative to COBRA Coverage. You (and any Dependents covered under the Fund on the day your leave started) may also be eligible to elect COBRA Coverage. Either COBRA Coverage or USERRA Coverage can be elected. Contact the Fund Office to obtain a copy of the COBRA and/or USERRA election forms. Completed USERRA election forms must be submitted to the Fund Office in the same timeframes as is permitted under COBRA.

USERRA Coverage operates in the same way as COBRA Coverage and, like COBRA Coverage, monthly premiums for USERRA Coverage will be 102% of the full cost of coverage for similarly-situated active Employees and their families. Payment of monthly premiums for USERRA Coverage and termination of USERRA Coverage due to non-payment of such premiums works just like with COBRA Coverage. See the COBRA description earlier in this Chapter for more details.

D. Termination of USERRA Coverage

Your USERRA Coverage may terminate early if: (1) you are discharged from military service and you do not return or reapply for work within the required timeframe after your military service ends; or (2) you do not have reemployment rights due to a less than honorable discharge from the military.

In addition to USERRA or COBRA Coverage, an Employee and his or her covered Dependents may be eligible for health care coverage under TRICARE (the Department of Defense health care program for uniformed service members and their families). The Fund coordinates benefits with TRICARE. You should carefully compare the benefits, costs, provider networks, and restrictions of the TRICARE plan to USERRA or COBRA Coverage to determine whether TRICARE coverage alone is sufficient or if temporarily continuing Fund coverage under USERRA or COBRA is the best choice.

Questions regarding your entitlement to USERRA Coverage should be directed to the Fund Office.

XIV
CLAIMS AND APPEALS PROCEDURES & THE EXTERNAL REVIEW PROCESS

In this Chapter, the terms "you" and "your" refer to the Participant (whether a covered Employee or covered Dependent) and the Authorized Representative of the Participant.

1. General Rules

A. Applicability

This Chapter describes the claims and appeals procedures and the external review process applicable to Claims (defined below in Section 2.A) for the benefits described in this booklet, with the following exceptions:

(1) Benefits provided under the Kaiser Permanente HMO Plan or the UnitedHealthcare HMO Plan. Claims for these benefits must be submitted to the appropriate HMO (Kaiser or UHC) and will be processed under that HMO's claims and appeals procedures.

(2) Dental benefits provided under the Indemnity Dental Plan. Claims for dental benefits under the Indemnity Dental Plan must be submitted to Delta Dental and will be processed under Delta Dental's claims and appeals procedures.

(3) Benefits provided under the United Concordia Dental HMO Plan. Claims for these benefits must be submitted to United Concordia and will be processed under United Concordia's claims and appeals procedures.

B. Eligibility Determinations

Disputes concerning eligibility determinations that are unrelated to any specific Claim and that are not Rescissions of Coverage, including appeals regarding eligibility for Fund coverage (including Extended Coverage and COBRA coverage), are not "Claims." The Fund will process those disputes in accordance with the procedures in Section 7 ("Eligibility Disputes") of this Chapter, below.

C. Types of Claims

The rules for submitting, processing, and appealing a Claim depends on the type of Claim filed. The following table lists Fund benefits that are subject to these claims and appeals procedures according to Claim type:

Non-Health Claims	*Health Claims*
• Supplementary Disability Benefits • Supplementary Unemployment Benefits • Supplementary Workers' Compensation Benefits • Death Benefits • Total and Permanent Disability Death Benefit	Indemnity Medical Plan Benefits, including for: • Medical • Mental health and substance use disorder • Prescription Drugs • Vision • Temporo-mandibular joint (TMJ) disorder • Podiatry • Hearing aids • Chiropractic care • Acupuncture • The Special Accident Benefit

D. Limitations on Legal Actions

Exhaustion of the Fund's Internal Claims and Appeals Procedures. You must first exhaust the Fund's internal claims and appeals procedures before you can file a civil action under ERISA Section 502(a) against the Fund or the Board of Trustees. This means that before you may take legal action, you must follow the procedures for filing an internal claim and an appeal as described in this Chapter.

There are certain exceptions to the requirement to exhaust the Fund's internal claims and appeals procedures as follows:

- *For Health Claims and Claims for the Total and Permanent Disability Death Benefit*: You may take legal action without first exhausting the Fund's internal claims and appeals procedures if the Fund fails to comply with the claims and appeals procedures that apply to your Claim. This exception, however, does not apply if the Fund's failure is minor, does not prejudice you, is attributable to good cause or matters beyond the Fund's control, occurs in the context of a good faith exchange of information between you and the Fund, and is not reflective of a pattern or practice of noncompliance. If this type of minor violation occurs, you may request a written explanation of the violation from the Fund. Within 10 days of your request, the Fund will respond to your request with a specific description of the violation and an explanation as to why the violation should not cause the internal claims procedures to be deemed exhausted.

- *For all other Claims*: You may take legal action without first exhausting the Fund's internal claims and appeals procedures if the Fund fails to substantially comply with the claims and appeals procedures applicable to your Claim, and it does not correct the error without prejudice to you.

External Appeals Procedures. You are not required to exhaust the Fund's external review process before seeking a judicial remedy.

Three-Year Limitation Period. The Fund imposes a 3-year limitation period on which you may file a lawsuit for benefits, as follows:

- **For Health Claims** - No lawsuit may be filed (started) more than 3 years after the end of the calendar year in which services were provided.

- **For Claims for Supplementary Disability or Unemployment Benefits** - No lawsuit may be filed (started) more than 3 years after the date that a State Disability claim, a State Unemployment claim, or a claim for a State-approved voluntary disability plan is established.

- **For Claims for Supplementary Workers' Compensation Benefits** - No lawsuit may be filed (started) more than 3 years after the date the Workers' Compensation claim was established or the date of the first payment by the Workers' Compensation Carrier, whichever was later.

- **For Claims for Death Benefits or the Total and Permanent Disability Death Benefit** - No lawsuit may be filed more than 3 years after the date of death.

2. Definitions

A. Claim

A "Claim" is a request for benefits submitted in accordance with these claims and appeals procedures and external review process. A Claim is not: (i) a mere request for information about Fund benefits; (ii) a dispute concerning eligibility for Fund benefits, including COBRA coverage, that is unrelated to any specific Claim; (iii) the presentation of a prescription to a pharmacy; or (iv) a request for prior approval where prior approval is not required by the Fund. There are two types of Claims: Non-Health Claims and Health Claims (which include Post-Service, Pre-Service, Urgent Care, and Concurrent Claims). The rules for submitting, processing, and appealing a Claim depends on the type of Claim filed.

B. Health Claim

A "Health Claim" is a Claim for medical benefits under the Indemnity Medical Plan (the "Plan"), including claims for mental health and substance use disorder services, Prescription Drugs, vision, TMJ, podiatry, hearing aid, chiropractic care, acupuncture, and the Special Accident Benefit). A claim for dental benefits under the Indemnity Dental Plan is not a Health Claim.

There are four types of Health Claims: Post-Service Claims, Pre-Service Claims, Urgent Care Claims, and Concurrent Claims.

(1) Post-Service Claim – A "Post-Service Claim" is a Health Claim for which approval is not required prior to obtaining services and that involves payment or reimbursement for care that has already been provided. Examples of Post-Service Claims include a paper or electronic Claim submitted for payment after services have been provided and Claims for services received in an Emergency. A Rescission of Coverage will be treated as a denied Post-Service Claim.

(2) Pre-Service Claim – A "Pre-Service Claim" is a Health Claim for which the payment will be reduced or services will not be covered unless Preauthorization is received prior to obtaining care (e.g., Claims for elective inpatient admissions).

(3) Urgent Care Claim – An "Urgent Care Claim" is a type of Pre-Service Claim for which the application of the time periods for making non-urgent care determinations: (a) could seriously jeopardize the patient's life, health, or ability to regain maximum function; or (b) in the opinion of a Physician with knowledge of the patient's medical condition, would subject the patient to severe pain that cannot be adequately managed without the care or treatment that is the subject of the Claim.

(4) Concurrent Claim – A "Concurrent Claim" is a Health Claim involving the early termination or reduction of an approved ongoing course of treatment or a request to extend treatment involving Urgent Care beyond what was initially approved.

C. Rescission of Coverage

A "Rescission of Coverage" is a cancellation or discontinuance of coverage that has a retroactive effect, except to the extent it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage.

The Plan is permitted to rescind coverage if a Participant (or a person seeking coverage on behalf of a Participant) has engaged in fraud or made an intentional misrepresentation of material fact.

A Rescission of Coverage can occur even if it has no adverse effect on any particular benefit at that time. Retroactive termination of an ex-Spouse's coverage due to the failure to timely notify the Fund Office of a divorce is not considered a Rescission of Coverage.

A Rescission of Coverage will be treated as the denial of a Post-Service Claim.

D. Non-Health Claim

A "Non-Health Claim" is a Claim for Supplementary Disability, Unemployment, or Workers' Compensation benefits, a Claim for Death Benefits, or a Claim for the Total and Permanent Disability Death Benefit.

3. Use of an Authorized Representative

An Authorized Representative may file a Claim, appeal a denied Claim, or request an external review of a disputed Health Claim for you, but only if you have designated the individual to act on your behalf with respect to the Claim at issue. Any reference to "you" in this Chapter also includes your Authorized Representative.

To designate someone as your Authorized Representative, the designation must be in writing on a form acceptable to the Board of Trustees, with one exception: a health care professional with knowledge of the patient's medical condition will be permitted to act as the patient's Authorized Representative for an Urgent Care Claim without further verification. Only an individual (a person) and not an entity (e.g., a corporation) can be an Authorized Representative.

You can obtain an "Appointment of Authorized Representative" form from the Fund's website at https://ufcwdrugtrust.org/app/uploads/2021/11/DrugFund.AuthorizedRepresentativeForm.pdf or by calling the Fund Office.

An Authorized Representative designation will be valid until it is revoked or otherwise expires. You may revoke a designation at any time by submitting a written request to revoke the designation to the Fund Office.

4. Health Claims – Claims and Appeals Procedures

A. Filing a Health Claim

PPO Providers and Participating Pharmacies will submit Health Claims for you. Other Providers (generally Non-PPO Providers and vision Providers) may also submit Health Claims on your behalf. If you need to file a Health Claim yourself, you can request a Medical Claim form, Prescription Reimbursement Claim form, or a Vision Claim form from the Fund Office or your Union Local. These forms are also available on the Fund's website as follows:

- **Medical:** https://ufcwdrugtrust.org/app/uploads/2022/01/Medical-Claim-Form-for-Participants.pdf

- **Prescription Drug:** https://ufcwdrugtrust.org/app/uploads/2023/03/Prescription-Reimbursement-Claim-Form.pdf

- **Vision:** https://ufcwdrugtrust.org/app/uploads/2021/11/2008-Vision-Claim-Form.pdf.

Post-Service Claims must be filed in writing or electronically on forms or in a format acceptable to the Fund or its designee.

Health Claims must be submitted to Anthem Blue Cross, with the following exceptions:

(1) All Claims for Prescription Drugs from a Participating Pharmacy and all Claims for Specialty Drugs must be submitted to Optum Rx. Generally, Participating Pharmacies and Specialty Pharmacies will submit claims to Optum Rx on your behalf. (However, you can file a Claim for Prescription Drugs with the Fund Office if you are not satisfied after seeking benefits from a Participating Pharmacy.)

(2) All Claims for Compound Drugs, Prescription Drugs subject to a one-time exception from the Participating Pharmacy requirement, and coordination of Prescription Drug benefits (i.e., Copay reimbursements) must be submitted to the Fund Office.

(3) All Claims for ancillary benefits, which includes vision care, hearing aids, the Special Podiatry Benefit, temporo-mandibular joint (TMJ) disorder, and Orthopedic Appliances/artificial limbs, as well as Claims for chiropractic care, acupuncture benefits, and the Special Accident Benefit must be submitted to the Fund Office.

Deadline for Filing Post-Service Claims. Post-Service Claims must be filed within one year after the date of service or they will be denied. A Claim is considered filed on the date it is received (or on the date postmarked, if mailed through the U.S. Postal Service) by the Fund or its designee, regardless of whether it contains all the information necessary to render a decision.

If you inadvertently submit your Claim to the incorrect entity (e.g., you submit a Claim for vision care to Anthem Blue Cross when it should have been submitted to the Fund Office) within this one-year filing period, then the time for filing will be extended to one year after the earlier of: (1) the date the Claim is denied by the incorrect entity; or (2) the date you are notified that you submitted the Claim to the incorrect entity.

If a PPO Provider does not file a Claim on time, the Provider can bill you only for the Copayment and/or Coinsurance you would have paid if the Provider had filed the Claim on time.

B. Claims Administrators

The "Claims Administrator" means either the Fund Office or an organization that has a contract with the Fund (e.g., Anthem Blue Cross) to determine the Fund's payment or financial responsibility by applying the terms of the Plan to a Health Claim. The Claims Administrator for each type of benefit is shown in the table below. Contact information for each Claims Administrator can be found in the Quick Reference Chart in the front of this booklet.

When the Claims Administrator is not the Fund Office: The Claims Administrator will process your Health Claim in accordance with its own procedures, which are not discussed in this Chapter. For a copy of the relevant Claims Administrator's procedures, contact the Fund Office or the Claims Administrator.

Claims Administrator	Types of Health Claims Processed
Fund Office	• Post-Service Claims for medical care (including mental health and substance use disorder services). • The following types of Claims for Prescription Drugs obtained from a non-Participating Pharmacy (i.e., an out-of-network pharmacy): (i) Prescription Drugs subject to a one-time exception from the Participating Pharmacy requirement; and (ii) Compound Drugs. • Post-Service Claims for podiatric services. • All Claims for ancillary benefits (vision, hearing aid, the Special Podiatry Benefit, TMJ, and Orthopedic Appliances/artificial limb). • All Claims for chiropractic and acupuncture benefits, the Special Accident Benefit, and coordination of Prescription Drug benefits (Copay reimbursement).
Anthem Blue Cross	• Pre-Service, Urgent Care, and Concurrent Claims for medical care, including Hospital stays. • Pre-Service, Urgent Care, and Concurrent Claims for mental health and substance use disorder benefits. • Pre-Service Claims for podiatry services.
Optum Rx (Prescription Drug Program)	• Claims for Prescription Drugs obtained from Participating Pharmacies, including Pre-Service and Urgent Care Claims for drugs requiring Preauthorization. • Claims for Specialty Drugs.

C. Processing a Health Claim

(1) Failure to Properly File a Pre-Service or Urgent Care Claim. If a communication from you is received by the Fund Office that fails to follow the Fund's procedures for filing Pre-Service or Urgent Care Claims, but you name the patient, the specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, you will be furnished with a notice of the failure to file a proper Claim and the correct procedures to be followed. This notice will be provided within: (a) 24 hours in the case of an Urgent Care Claim; or (b) 5 days in the case of a non-urgent Pre-Service Claim. This notice may be oral, unless you request written notification.

(2) Time Period for Processing Claims. Claims will be processed within the time periods shown below. You can voluntarily allow the Claims Administrator more time to process your Claim.

(a) ***Post-Service Claim*** – A Post-Service Claim will be processed within 30 days after it is filed. This 30-day period may be extended by up to an additional 15 days if necessary due to matters beyond the Claims Administrator's control. You will be notified of any extension before it is taken, the reason for the extension, and the date a decision is expected. If you are asked to submit information necessary to decide your Claim, you will be given at least 45 days to respond, and the time for the Claims Administrator's decision will be suspended

(i.e., tolled) from the date of the extension notice to the earlier of the date you respond or the due date set by the Claims Administrator.

(b) ***Pre-Service Claim*** – A Pre-Service Claim will be processed within 15 days after it is received by the Claims Administrator. This 15-day period may be extended by up to an additional 15 days if necessary due to matters beyond the Claims Administrator's control. You will be notified of an extension before it is taken, the reason for the extension, and the date a decision is expected. If you are asked to submit information necessary to decide your Claim, you will be given at least 45 days to respond, and the time for the Claims Administrator's decision will be suspended (i.e., tolled) from the date of the extension notice to the earlier of the date you respond or the due date set by the Claims Administrator.

(c) ***Urgent Care Claim*** – An Urgent Care Claim will be processed as soon as possible, taking into account medical exigencies, but not later than 72 hours after it is filed. If your Claim is denied, the denial notice may be provided in writing or orally; however, an oral notice will be followed by a written notice within 3 days. If additional information is necessary to process your Claim, you or your Physician will be notified, within 24 hours after your Claim is filed, of the additional information required, and you will be given at least 48 hours to respond. You will be notified of the Claims Administrator's decision on your Claim within 48 hours after the earlier of its receipt of the specified information or the due date set by the Claims Administrator.

(d) ***Concurrent Claim***

(i) If a pre-approved course of treatment or number of treatments is reduced or prematurely terminated (other than by plan amendment or termination), such reduction or termination will be treated as a Claim denial. The Claims Administrator will notify you of such denial sufficiently in advance to allow you to appeal and obtain a decision on appeal before the benefit is reduced or terminated.

(ii) Any request to extend a course of treatment beyond the pre-approved period of time or number of treatments that is an Urgent Care Claim will be decided within 24 hours after the receipt of your request, but only if the request was made at least 24 hours before the expiration of the approved period of time or number of treatments. Otherwise, the decision will be made as soon as possible, but no later than 72 hours after your request is made.

(3) Contents of Initial Denial Notice. If your Claim is denied, in whole or in part, you will receive a denial notice that:

(a) Identifies the Claim involved and includes the date(s) of service, the Health Care Provider, and the Claim amount (if applicable).

(b) States the specific reason(s) for the denial, the denial code and its corresponding meaning, and a description of Plan standard(s), if any, used in the denying the Claim.

(c) Refers to the specific Plan provision(s) on which the denial is based.

(d) States that the Claims Administrator will provide you, free of charge, the applicable diagnosis and treatment codes (along with their corresponding meanings) if requested in writing.

(e) States, if applicable, that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying the Claim and that a copy of such rule, guideline, protocol, or other criterion will be provided to you, free of charge and upon request.

(f) If the denial is based on a Medical Necessity or experimental treatment or similar exclusion or limit, states that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request.

(g) Describes any additional material or information necessary for you to perfect your Claim and explains why such material or information is necessary.

(h) Describes the Claims Administrator's internal appeal procedures, including the time limits applicable to such procedures and information on how to file an appeal, as well as the Claims Administrator's external review process and the time limits applicable to such process. For Urgent Care Claim denials only, this description will also include information about the expedited review process applicable to such Claims.

(i) States that you are entitled to receive, upon request, free access to and copies of documents relevant to your Claim.

(j) Includes a statement of your right to bring a civil action under ERISA Section 502(a) following either: (i) the denial of your Claim on appeal; or (ii) the denial of your Claim under the Claim Administrator's external review process.

D. Filing an Appeal of a Denied Health Claim

If your Health Claim is denied, in whole or in part, you may file an appeal.

Your appeal must be filed within 180 days after you receive the written denial notice (such as an EOB). Your appeal is considered filed on the date it is received (or on the date postmarked, if mailed through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

Appeals, including appeals of denied Post-Service Claims and appeals concerning Claims for Prescription Drugs, must be submitted to the Fund Office, with the following exceptions:

- Appeals of denied Pre-Service, Urgent Care, and Concurrent Claims for medical care (including mental health and substance use disorder services) must be submitted to Anthem Blue Cross and will be processed in accordance with Anthem's appeals procedures.

- Appeals of denied Pre-Service and Urgent Care Claims for Prescription Drugs requiring Preauthorization must be submitted to the Fund Office.

- Appeals of denied Pre-Service Claims for podiatry services must be submitted to Anthem Blue Cross and will be processed in accordance with Anthem's appeals procedures.

For Appeals Decided by Anthem Blue Cross: Any appeal submitted to Anthem will be processed in accordance with Anthem's own appeals procedures, which are not discussed in this Chapter. For a copy of Anthem's procedures, contact the Fund Office or Anthem Blue Cross. If, after exhausting the appeals process through the Anthem, your Health Claim continues to be denied, in whole or in part, you may (but are not required to) submit your appeal to the Fund Office for a voluntary second-level review in accordance with the procedures below. Submitting your appeal to voluntary second-level review by the

Fund Office will not affect the time limits for requesting any available external review or bringing action under ERISA Section 502(a).

For Appeals Processed by the Fund Office: Your appeal must be in writing and include your name, mailing address, telephone number, and the basis for your appeal. You may submit written comments, documents, records, evidence, testimony, and other information relating to your Claim to support your appeal. An appeal of an Urgent Care Claim, however, may be submitted orally, and you may submit any information in support of your appeal orally, by facsimile, or by other available expeditious method.

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim, including your claim file. You will be provided, upon request, the identity of any medical or vocational expert whose advice was obtained on behalf of the Fund in connection with the denial of your Claim, regardless of whether the advice was relied upon in denying the Claim. You will be provided, free of charge: (i) any new or additional evidence considered, relied upon, or generated in connection with your Claim; and (ii) any new or additional rationale for a denial at the internal appeals stage. This information will be provided to you as soon as possible, sufficiently before the decision on appeal is made, so that you will have a reasonable opportunity to respond before a final decision on appeal is rendered.

You may submit written comments, documents, records, evidence, testimony and other information relating to the Claim, which will be considered on appeal regardless of whether such information was submitted or considered in the initial Claims review.

E. Processing an Appeal of a Denied Health Claim

(1) The Fund's Appeal Review Procedure. Your appeal of a denied Health Claim will receive a full and fair review by the Board of Trustees or its designee, the Appeals Committee, and the party deciding the appeal will not be the same individual who denied your Claim, nor the subordinate of such individual. In deciding your appeal, the Board or Committee will make an independent determination and will not afford deference to the initial review. The Board or Committee will consider all of the written comments, documents, records, evidence, testimony, and other information submitted by you that relates to your Claim, regardless of whether such information was submitted or considered in the initial review. If the denial was based on medical judgment, the Board or Committee will consult with an appropriate health care professional who has experience in the field of medicine involved in your Claim and who was not consulted in connection with the initial denial, nor is the subordinate of any such individual.

You have no right to appear personally before the Board or Committee. The Board or Committee will exercise its reasoned discretion and authority in making, interpreting, and applying Plan rules, and in resolving any appeals. The decision of the Board or Committee will be conclusive and binding upon all persons and for all purposes, except in the limited circumstance that a disputed Health Claim is submitted to the external review process, in which case the decision of the Independent Review Organization (IRO) will be final.

(2) Time Period for Processing an Appeal. Your appeal will be decided within the time periods shown below. You can voluntarily agree to extend the time for the Fund to decide your appeal.

(a) ***Post-Service Claims*** – Your appeal will be decided at the Board or Committee meeting that occurs at least 30 days after your appeal is filed. The time for deciding your appeal may be extended to the third meeting after your appeal is filed if special circumstances require an extension of time for processing, or longer if you are asked to submit information

necessary to make a determination on the appeal. You will be notified of an extension before it is taken, the reason for the extension, and the date a decision is expected. If you are asked to submit information necessary to decide your appeal, you will be given at least 45 days to respond, and the time for the Board's or Committee's decision will be suspended (i.e., tolled) from the date of the extension notice until the earlier of the date you respond or the due date set by the Board or Committee. You will be notified in writing of the decision within 5 days after it is made.

(b) ***Pre-Service Claims*** – You will be notified in writing of the decision within 30 days after your appeal is filed.

(c) ***Urgent Care Claims*** – You will be notified of the decision as soon as possible, but not later than 72 hours, after your appeal is filed. This notice may be provided orally, by facsimile, or by other similarly expeditious method, followed by a written notice within 3 days.

(d) ***Concurrent Claims*** – If your request to extend a concurrent care course of treatment is denied, you will be provided with a notice of the decision as soon as possible, but not later than 72 hours after your appeal is filed. Notwithstanding the previous sentence, your request to extend a course of treatment that does not involve urgent care will be decided in the normally applicable determination period, as it is not a Concurrent Claim.

(3) Contents of Appeal Denial Notice. If your Claim is denied on appeal, you will receive a denial notice that:

(a) Identifies the Claim involved and includes the date(s) of service, the Health Care Provider, and the Claim amount (if applicable).

(b) States the specific reason(s) for the denial on appeal, the denial code and its corresponding meaning, and a description of Plan standard(s), if any, that was used in denying the Claim on appeal (including a discussion of the decision).

(c) Refers to the specific Plan provision(s) on which the denial is based.

(d) States, if applicable, that an internal rule, guideline, protocol, or other similar criterion was relied upon in denying your Claim on appeal, and that a copy of such specific rule, guideline, protocol, or other criterion will be provided to you, free of charge and upon request.

(e) If the denial of your Claim on appeal is based on a Medical Necessity or experimental treatment or similar exclusion or limit, states that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request.

(f) States that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim.

(g) States that the Fund Office will provide you, free of charge, the applicable diagnosis and treatment codes (along with their corresponding meanings) if requested in writing.

(h) Includes a statement of your right to request an external review by an independent review organization and describes the Plan's external review process.

(i) Includes a statement of your right to bring a civil action under ERISA Section 502(a)

following either: (i) the denial of your Health Claim on appeal; or (ii) the denial of your Health Claim under the Plan's external review process.

F. Recourse after Denial of a Health Claim on Appeal

If your Health Claim is denied on appeal, in whole or in part, you have the following options:

(1) You may submit the disputed Health Claim to the external review process (described in Section 5 of this Chapter, below), if applicable.

(2) In the alternative, you may bring an action under ERISA Section 502(a).

(3) You may also bring an action under ERISA Section 502(a) after exhausting the external review process. (However, you may only use the external review process once for any disputed Health Claim.)

5. External Review Process – Health Claims Only

A. Applicability

If your Health Claim is denied or if your Fund coverage is terminated retroactively, you may be able to have the decision reviewed by an Independent Review Organization (IRO), free of charge, through a process called "external review."

Only the following types of denials are eligible for external review:

(1) A Health Claim denial involving medical judgment, as determined by the IRO (for example, if your Claim was denied because the treatment was not Medically Necessary or was Experimental or Investigational).

(2) A Health Claim denial relating to NSA Services.

(3) A Rescission of Coverage.

External review is not available for any other type of denial. Furthermore, external review is not available for Health Claim denials based on ineligibility for coverage or for dental or vision benefits, regardless of the reason for denial.

B. Submitting a Request for External Review

(1) When External Review Becomes Available. You may request an external review of a disputed Health Claim after the occurrence of any of the following:

(a) The denial of your Health Claim on appeal.

(b) The denial of your Urgent Care Claim at the initial level, but only if you have also filed an internal appeal along with your external review request.

(c) The exhaustion or deemed exhaustion of the internal claims and appeals procedures for Health Claims described above, but only if your Health Claim remains unresolved.

(2) Types of External Review. There are two types of external review: (i) standard external review; and (ii) expedited external review. Expedited external review may be requested only if:

(a) Your Urgent Care Claim has been denied at the initial level, and you have also filed an internal appeal along with your external review request; or

(b) Your Urgent Care Claim has been denied on appeal; or

(c) Your Concurrent Claim has been denied on appeal, and the denial concerns an admission, availability of care, continued stay, or health care item or service for which Emergency Services were received, but the patient has not yet been discharged from a Facility.

(3) Requirements. Your request for external review (whether standard or expedited) must be submitted to the Claims Administrator, as follows:

(a) Requests for external review of Pre-Service, Urgent Care, and/or Concurrent Claim denials must be submitted to Anthem Blue Cross, if Anthem Blue Cross decided the Claim at the initial level. In this case, Anthem will be the Claims Administrator and will administer the external review process.

(b) All other requests for external review must be submitted to the Fund Office, which will be the Claims Administrator administering the external review process for the request.

All requests for standard external review must be in writing.

(4) Deadlines for Requesting External Review.

(a) If your Claim was denied on appeal, you must submit your external review request within 4 months after you receive the appeal denial notice.

(b) If your Claim was denied, but a decision on appeal has not yet been reached (either because you have an Urgent Care Claim on appeal or because you are deemed to have exhausted the administrative remedies available to you), you must submit your external review request within 4 months after you received the initial denial notice.

(5) Cost. There is no cost to you to request an external review.

C. Preliminary Review by the Claims Administrator

(1) Eligibility for External Review. The Claims Administrator will conduct a preliminary review to determine whether your request is eligible for external review by considering the following factors:

(a) Whether the patient is/was covered under the Fund at the time the health care item or service is/was requested or provided;

(b) Whether the Claim denial relates to the patient's failure to meet the Fund's requirements for eligibility;

(c) Whether the Claim denial involves medical judgment, NSA Services, or a Rescission of Coverage;

(d) Whether you have exhausted (or are deemed to have exhausted) the Claims Administrator's internal claims and appeals procedures, unless not required; and

(e) Whether you have provided all of the information and forms required to process an external review.

(2) Notice of Decision

(a) The Claims Administrator will complete its preliminary review and notify you in writing whether your request is eligible for external review:

(i) ***For standard external review*** – Within 6 business days after it receives your request.

(ii) ***For expedited external review*** – Immediately after it receives your request.

(b) The written notification will state one of the following:

(i) That your request is complete and eligible for external review; or

(ii) That your request is complete but not eligible for external review, the reasons for ineligibility, and the contact information for the Employee Benefits Security Administration; or

(iii) That your request is not complete, the information or materials needed to complete the request, and instructions for perfecting (i.e., completing) the request by submitting the required information or materials within the 4-month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

D. Review by an Independent Review Organization (IRO)

(1) Assignment of your Request to an IRO. If your request is eligible for external review, it will be assigned to an accredited independent review organization (IRO), which will conduct the external review. (Note that the IRO is not eligible for any financial incentive based on the likelihood that the IRO would support the denial of benefits). Once the claim is assigned to an IRO, the procedures in this Subsection D will apply.

(2) Your Right to Submit Additional Information to the IRO. The IRO will notify you in writing that it has accepted your request for external review and provide you information about how you may submit additional information regarding your Claim. Within 10 business days of receiving this notice, you may submit additional written information regarding your Claim to the IRO, which the IRO must consider when conducting the external review.

(3) Reconsideration by the Claims Administrator. Any additional written information that you submit to the IRO will be forwarded to the Claims Administrator. Upon receipt of the information, the Claims Administrator may reconsider its denial of your Claim, and such reconsideration will not delay the external review. If, upon reconsideration, the Claims Administrator decides to reverse its denial, it will notify you and the IRO of its decision within one business day after making that decision, and the IRO will terminate its external review.

(4) Submission of Information to the IRO. The Claims Administrator will provide the IRO with any documents and information that it considered in denying your Claim:

(a) ***For standard external review*** – Within 5 business days after the request has been assigned to the IRO.

(b) ***For expedited external review*** – Expeditiously (i.e., via telephone, fax, courier, overnight delivery, etc.) after the request has been assigned to the IRO.

If the Claims Administrator fails to comply with this requirement, the IRO may terminate the external review and reverse the denial, in which case the IRO will notify you and the Claims Administrator within one business day of making its decision.

(5) External Review Procedure. The IRO will review all of the information and documents timely received. In addition, the IRO may consider additional information (for example, information from the patient's medical records, recommendations or other information from the patient's treating (attending) Health Care Providers, other information from you or the Claims Administrator, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Claims Administrator's applicable clinical review criteria, and/or the opinion of the IRO's clinical reviewer and/or legal expert). In reaching a decision, the IRO will review the Claim as if it is new and will not be bound by any decisions or conclusions reached during the internal claims and appeals process. However, the IRO must observe the terms of the Plan to ensure that its decision is not contrary to such terms, 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.

(6) Notice of Final External Review Decision

(a) The IRO will notify you and the Claims Administrator of its final external review decision within the following time periods:

(i) ***For standard external review*** – In writing within 45 days after the IRO receives your external review request.

(ii) ***For expedited external review*** – As expeditiously as the patient's medical condition or circumstances require, but in no event more than 72 hours after the IRO receives your external review request. If such notice is not in writing, the IRO must provide written confirmation of its decision to you, and as well as to the Claims Administrator, within 48 hours after the date of providing the non-written notice.

(b) The IRO's notice will contain the following:

(i) A description of the reason for the external review request.

(ii) Information sufficient to identify the Claim, including the date(s) of service, the Health Care Provider, the Claim amount (if applicable), and the reason for the previous denial.

(iii) The date the IRO received the external review request, and the date of the IRO's decision.

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

(v) 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.

(vi) A statement that the IRO's determination is binding, except to the extent that the dispute is submitted to binding arbitration pursuant to applicable State law.

(vii) Current contact information, including a 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.

E. Procedure Following IRO's Final Decision

If the IRO reverses the Claims Administrator's decision to deny your Claim, the Fund will provide coverage or payment for your Claim upon receipt of the IRO's notice. If the IRO upholds the Claims Administrator's denial, you may bring an action under ERISA Section 502(a).

6. Non-Health Claims – Claims and Appeals Procedures

The claims and appeals procedures set forth in this Section 6 apply to Non-Health Claims only (referred to in this Section simply as "Claims").

A. Filing a Non-Health Claim

Claims must be filed in writing with the Fund Office on a form acceptable to the Board of Trustees within the deadlines listed below or they will be denied. A Claim is considered filed on the date it is received by the Fund Office (or on the date postmarked, if mailed through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

(1) ***Supplementary Disability or Unemployment Benefits*** – Claims must be filed within one year after an Employee's State Disability claim, State Unemployment claim, or claim with a State-approved voluntary disability plan is established.

(2) ***Supplementary Workers' Compensation Benefits*** – Claims must be filed within one year after the later of: (i) the date an Employee's Workers' Compensation claim is established; or (ii) the date of the first payment by the Workers' Compensation Carrier.

(3) ***Death Benefits*** – Claims must be filed within one year after the date of death. However, written notice of a Claim for the Felonious Death Benefit must be provided to the Fund Office within 90 days after the Employee's death or as soon thereafter as reasonably possible. Proof of the Employee's Death as the result of a felonious assault must be furnished no later than 12 months from the Employee's date of Death.

(4) ***Total and Permanent Disability Death Benefit*** – Claims must be filed within one year after the Employee's date of death.

B. Processing a Non-Health Claim

(1) Time Period for Processing Claims. You will be notified, in writing, of the Fund's decision within 90 days after your Claim is filed. This 90-day period may be extended by up to an additional 90 days if special circumstances require an extension of time for processing. You will be notified of

an extension before it is taken, the reason for the extension, and the date a decision is expected. You can voluntarily allow the Fund more time to process your Claim.

(2) Contents of Initial Denial Notice. If your Claim is denied, in whole or in part, you will receive a written denial notice that:

(a) States the specific reason(s) for the denial.

(b) Refers to the specific Plan provision(s) on which the denial is based.

(c) Describes any additional material or information necessary for you to perfect your Claim and explains why such material or information is necessary.

(d) Describes the Plan's internal appeal procedures, including the time limits applicable to such procedures and information on how to file an appeal.

(e) States that you are entitled to receive upon request, free access to and copies of documents, records, and other information relevant to your Claim.

(f) States your right to bring a civil action under ERISA Section 502(a) following the denial of your Claim on appeal.

C. Filing an Appeal of a Non-Health Claim Denial

You may file an appeal if your Claim is denied, in whole or in part. Your appeal must be filed with the Fund Office within 60 days after you receive the written denial notice. Your appeal is considered filed on the date it is received by the Fund Office (or on the date postmarked, if mailed through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision.

Your appeal must be in writing and include your name, mailing address, telephone number, and the basis for your appeal. You may submit any written comments, documents, records, evidence, testimony, and other information relating to your Claim to support your appeal.

You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim.

D. Processing an Appeal of a Non-Health Claim Denial

(1) Appeal Review Procedure. Your appeal will receive a full and fair review by the Board of Trustees or the Appeals Committee. The Board or Committee will consider all of the written comments, documents, records, evidence, testimony, and other information submitted by you that relates to your Claim, regardless of whether such information was submitted or considered in the initial review. You have no right to appear personally before the Board or Committee. The Board or Committee will exercise its reasoned discretion and authority in making, interpreting, and applying Fund rules, and in resolving any appeals. The decision of the Board or Committee will be conclusive and binding upon all persons and for all purposes.

(2) Time Period for Processing an Appeal. Your appeal will be decided at the Board or Committee meeting that occurs at least 30 days after your appeal is filed. The time for deciding your appeal may be extended to the third meeting after your appeal is filed if special circumstances require an extension of time for processing, or longer if you are asked to submit information necessary to make a determination on the appeal. You will be notified of an extension before it is taken,

the reason for the extension, and the date a decision is expected. If you are asked to submit information necessary to decide your Claim, you will be given at least 45 days to respond, and the time for the Board's or Committee's decision will be suspended (i.e., tolled) from the date of the extension notice until the earlier of the date you respond or the due date set by the Fund. You will be notified in writing of the decision within 5 days after it is made. You can allow the Fund more time to decide your appeal.

(3) Contents of Appeal Denial Notice. If your Claim is denied on appeal, you will receive a written denial notice that:

(a) States the specific reason(s) for the denial.

(b) Refers to the specific Plan provision(s) on which the denial is based.

(c) States that you are entitled to receive, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim

(d) States your right to bring an action under ERISA Section 502(a).

E. Additional Rules Applicable to Claims and Appeals for the Total and Permanent Disability Death Benefit

The claims and appeals procedures described in this Section 6 ("Non-Health Claims – Claims and Appeals Procedures") apply to Claims for the Total and Permanent Disability Death Benefit, with the following exceptions:

(1) Time Period for Processing Claims. You will be notified, in writing, of the Fund's decision within 45 days after your Claim is filed. This 45-day period may be extended twice, by up to an additional 30 days each time, if necessary due to matters beyond the control of the Fund. Any required notice of extension will also explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on your Claim, and the additional information needed to resolve those issues. If you are asked to submit information necessary to decide your Claim, you will be given at least 45 days to respond, and the time for the Fund's decision will be suspended (i.e., tolled) from the date of the extension notice to the earlier of the date you respond or the due date set by the Fund.

(2) Filing and Processing an Appeal of a Claim Denial

(a) Your appeal must be filed within 180 days after you receive the written denial notice.

(b) You will be provided, upon request, the identity of any medical or vocational expert whose advice was obtained on behalf of the Fund in connection with the denial of your Claim, regardless of whether the advice was relied upon in denying the Claim.

(c) You will be provided, automatically and free of charge: (i) any new or additional evidence considered, relied upon, or generated in connection with your Claim; and (ii) any new or additional rationale for a denial at the internal appeals stage. This information will be provided to you as soon as possible, sufficiently before the decision on appeal is made, so that you will have a reasonable opportunity to respond before a final decision on appeal is rendered.

(d) The party deciding the appeal will not be the same individual who denied the Claim, nor the

subordinate of such individual.

(e) The Board or Committee will make an independent determination and will not afford deference to the initial review.

(f) If the denial was based on medical judgment, the Board or Committee will consult with an appropriate health care professional who was neither consulted in connection with the initial denial nor the subordinate of such individual.

(3) Contents of Initial and Appeal Denial Notices. Any initial and appeal denial notices will be provided in a culturally and linguistically appropriate manner and include the following additional information:

(a) A discussion of the decision, including, if applicable, an explanation of the basis for disagreeing with or not following any Social Security Administration disability determination or the views of the health care or vocational professionals presented by you or obtained by the Fund;

(b) The specific internal rules, guidelines, protocols, standards, or similar criteria of the Fund relied upon in denying the Claim, or alternatively, a statement that such information does not exist; and

(c) If the denial is based on a Medical Necessity or experimental treatment or similar exclusion or limit, a statement that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request.

7. Eligibility Disputes

The following procedures apply to disputes concerning eligibility determinations that are unrelated to any specific Claim and that are not Rescissions of Coverage, including appeals regarding eligibility for Fund coverage (including Extended Coverage and COBRA Coverage).

If your eligibility or enrollment request is denied, you may file an appeal with the Fund Office. The appeal must be in writing and include your name, mailing address, telephone number, and the basis of the appeal. You may submit any written comments, documents, records, evidence, testimony, and other information to support your appeal.

The appeal must be filed with the Fund Office within 180 days after your enrollment request was denied. Your appeal is considered filed on the date it is received by the Fund Office (or on the date postmarked, if mailed through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision. The Board of Trustees or the Appeals Committee may consider a late appeal if it concludes the delay in filing was for reasonable cause.

The appeal will receive a full and fair review by the Board of Trustees or the Appeals Committee. The Board or Committee will consider all of the written comments, documents, records, evidence, testimony, and other information submitted by you in support of your appeal. The Board or Committee will exercise its reasoned discretion and authority in making, interpreting, and applying Fund rules, and in resolving any appeals. The decision of the Board or Committee will be conclusive and binding upon all persons and for all purposes.

The appeal will be decided at the Board or Committee meeting that occurs at least 30 days after the appeal is filed. The time for deciding the appeal may be extended to the third meeting after the appeal is

filed if special circumstances require an extension of time for processing, or longer if you are asked to submit information necessary to make a determination on the appeal. You will be provided with a written notice of the decision within 20 days after the Board or Committee makes its decision.

8. Facility of Payment

If the Board of Trustees or its designee determines that you cannot submit a Claim or prove that you or your covered Dependent paid any or all of the charges for health care services that are covered by the Plan because you are incompetent, incapacitated, or in a coma, the Fund may, at its discretion, pay Plan benefits directly to the Provider(s) who provided the health care services or supplies, or to any other individual who is providing for your care and support. Any such payment of Plan benefits will completely discharge the Fund's obligations to the extent of that payment. Neither the Fund, the Board of Trustees, a Claims Administrator, nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

XV
WORKERS' COMPENSATION & THIRD PARTY LIABILITY

In this Chapter, the terms "you" and "your" refer to the Participant, which includes both Employees and Dependents covered under the Indemnity Medical Plan.

1. Workers' Compensation

The following rules related to work-related illness or injury are for Participants in the Indemnity Medical Plan. If you are enrolled in an HMO medical plan through the Fund, you must follow the rules of your HMO plan.

The Fund does not provide benefits for the treatment of illnesses or injuries that are covered by Workers' Compensation or occupational disease laws. If you experience a work-related illness or injury (including but not limited to being injured while at work), you should file a workers' compensation claim with your employer. If your employer denies your workers' compensation claim, you must appeal the denial through your employer's workers' compensation carrier. Your appeal must be filed with a Division of Workers' Compensation District Office, also known as the Workers' Compensation Appeals Board office, as an Application for Adjudication.

For a Claim involving a work-related illness or injury to be considered for payment under the Indemnity Medical Plan, you must submit to the Fund Office a copy of (1) the workers' compensation denial notice, and (2) the Application for Adjudication. The Fund Office will then file a Notice and Request for Allowance of Lien with respect to any expenses for the treatment of the work-related illnesses or injuries alleged to be covered under workers' compensation or occupational disease law. The Fund's Notice and Request for Allowance of Lien will be issued to you for signature. Upon receipt of your signature for the Fund's Notice and Request for Allowance of Lien, any pending claims related to your work-related illness or injury will be processed as claims for benefits under the Indemnity Medical Plan and paid accordingly. The Fund will seek satisfaction of its lien with respect to benefits provided by the Indemnity Medical Plan with the applicable Workers' Compensation program or carrier or through the Workers' Compensation Appeals Board.

YOU MUST IMMEDIATELY NOTIFY THE FUND OFFICE WHEN YOU FILE A CLAIM FOR COVERAGE UNDER WORKERS' COMPENSATION IF A CLAIM FOR THE SAME INJURY OR ILLNESS HAS BEEN OR WILL BE MADE UNDER THE INDEMNITY MEDICAL PLAN.

2. Third Party Liability

The following rules related third party liability are for Participants in the Indemnity Medical Plan. If you are enrolled in an HMO medical plan through the Fund, you must follow the rules of your HMO plan.

If any benefits are payable to you under the Indemnity Medical Plan with respect to any injury, illness, or death caused by a third party, you agree that the Fund will be reimbursed out of any amounts you (or any successor(s) in interest, including but not limited to a parent, an heir, an estate, guardian, or personal representative) recover from any party alleged to have caused or contributed to such injury, illness, or death, or any insurer or other person acting on behalf of such a party. The Fund shall have a first-dollar lien against the entire amount of any such recovery, to the extent of all benefits paid or payable under the Indemnity Medical Plan to you with respect to any injury, illness, or death for which you recover any money, whether as a result of a judgment, settlement, or other award or monetary payment. The Fund's

lien and right to reimbursement has first priority against the entire recovery, even if you are not compensated for all your losses or damages, and even if some or all of the recovery is attributed to damages other than medical expenses for you.

The Fund's lien shall not exceed the full amount that the Indemnity Medical Plan has paid for benefits related to your injury, illness or death. No lien shall apply to any amount received under any uninsured motorist or underinsured motorist coverage in a policy of insurance on which the injured party is a named insured.

Whenever you submit a claim for benefits, you must notify the Fund Office if you believe a third party may be responsible or at fault for any illness, injury, or death. You must also do whatever is necessary to secure the reimbursement and lien rights of the Fund. You are required to:

(1) Promptly notify the Fund when a claim or lawsuit is filed against an allegedly responsible third party that is related to any injury, illness, or death for which benefits are payable under the Indemnity Medical Plan;

(2) Sign and execute the Fund's reimbursement agreement and acknowledgment of lien as a precondition to receiving benefits from the Fund;

(3) Promptly respond to any requests for information from the Fund regarding your claim or lawsuit; and

(4) Promptly notify the Fund when a recovery is obtained from any source and reimburse the Fund to the extent of its lien. This must be done before the recovery is paid to anyone else, including you.

The Fund may suspend or offset benefits otherwise payable to you in order to secure and satisfy its lien. Your failure to sign the reimbursement agreement and lien acknowledgment shall not constitute a waiver of the Fund's lien or right to reimbursement, regardless of whether benefits are paid on your behalf. In addition, if you fail to comply with any of the Fund's requirements for securing the Fund's reimbursement and lien rights, the Fund has the right to take legal action against you. The Fund may also file notice of its lien and reimbursement rights with any person affected by them, including but not limited to the court in which any action is filed, the attorney representing you, and any third party allegedly responsible for the injury, illness, or death giving rise to the action for recovery.

A. Adjustment of Liens

The Board of Trustees may accept less than the full amount of benefits paid or payable under the Indemnity Medical Plan in satisfaction of the Fund's lien. The Administrator is authorized to reduce the Fund's lien in circumstances where the net recovery (as defined below) does not exceed $100,000.00. Specifically, the Fund will accept the lesser of:

(1) Two-thirds of the Fund's lien; or

(2) Fifty percent of the first $25,000 of any net recovery, plus 75% of any excess.

"Net recovery" means the total amount paid or payable to or on behalf of an injured party, less attorney's fees and costs actually expended by or on behalf of the injured party.

An injured party, or an attorney acting on his or her behalf, may request further reduction of the lien and reimbursement obligation under the Fund by written request to the Board of Trustees. (In the case of recoveries exceeding $100,000.00, any request for reduction must be approved by the Board of Trustees

or such other person or persons as they may direct.) The Board of Trustees will review any information, documents, and discussion submitted in determining the appropriateness of any requested reduction in the Fund's lien. Factors for consideration may include loss of earnings, out-of-pocket expenses, anticipated unreimbursed future medical expenses, the permanence of the injuries, and the impact of the injuries on future employment, earning potential, and quality of life.

Regardless, the Fund shall not make any reduction in its lien if: (1) the Fund becomes involved in any litigation or other legal proceedings to enforce its lien or to recover any amount which you are required to reimburse to the Fund, or to defend against any claim related to the Fund's reimbursement and lien rights, or (2) if the Board of Trustees determines that you, or your attorney, has attempted to evade or avoid the Fund's lien. Evasion and avoidance of the lien include, but are not limited to, the failure to advise the Fund that any injury, illness, or death was caused by a third party, the failure to execute the Fund's reimbursement agreement and acknowledgment of the Fund's lien, or the failure to timely notify the Fund of any recovery.

B. When a Participant or Beneficiary Does Not Comply with Lien Procedures

When a Participant does not comply with the provisions of this section, the Fund may deny payment of any Claims and deny or reduce future benefits payable (including payment of future benefits for other injuries or illnesses) under the Indemnity Medical Plan by the amount of the Fund's lien. If the Fund brings an action against a Participant to enforce the provisions of this section, the amount of the Fund's lien shall include the Fund's attorneys' fees and costs.

XVI
GENERAL PROVISIONS & INFORMATION REQUIRED BY ERISA

Name of the Plan

The Southern California Drug Benefit Fund

Employer Identification Number (EIN)

95-6474516

Type of Plan

Employee Welfare Benefit Plan

Plan Number

501

Type of Administration

The Fund's benefits, except for the HMO Plans and the United Concordia Dental HMO Plan, are self-funded.

The Fund's self-funded benefits, except for dental benefits provided under the Indemnity Dental Plan, are administered by the Board of Trustees with the assistance of a Trust Fund Administrator and staff of the Southern California Drug Benefit Fund. The Board of Trustees also employs other personnel, including consultants, actuaries, attorneys, and accountants.

Self-funded dental benefits provided under the Indemnity Dental Plan are administered by Delta Dental.

Independent HMOs (whose names and addresses are listed on the Quick Reference Chart in the front of this booklet) administer the HMO Plans and provide payment of claims associated with those benefits.

United Concordia administers the United Concordia Dental HMO Plan and provides payment of claims associated with those benefits.

Plan Administrator

The Plan Administrator is the Board of Trustees of the Southern California Drug Benefit Fund.

Name of Plan Sponsor

The Plan Sponsor is the Board of Trustees of the Southern California Drug Benefit Fund.

Address & Telephone Number of Plan Administrator and Plan Sponsor

Board of Trustees
Southern California Drug Benefit Fund
2220 Hyperion Avenue
Los Angeles, CA 90027
(323) 666-8910

Plan Trustees

The Trustees of the Plan are:

Employer Trustees	Union Trustees
Edna Bechara Director of Benefits Rite Aid Corporation 200 Newberry Commons Etters, PA 17319	**Matt Bruno** Secretary-Treasurer UFCW Local 1167 855 W. San Bernardino Avenue Bloomington, CA 92316-2176
Steven Estrada Sr. Director, Human Resources Business Partner Kaiser Permanente Anaheim Medical Center, HR (MOB 1) 3460 E. La Palma Avenue Anaheim, CA 92806	**Kathy Finn** President UFCW Local 770 630 Shatto Place Los Angeles, CA 90005
Tom Guz Lead Director, Labor Relations CVS Health One CVS Drive Woonsocket, RI 02895	**Mark Ramos** President UFCW Local 1428 705 W. Arrow Highway Claremont, CA 91711
	Michael Straeter President UFCW Local 1442 9075 S. La Cienega Blvd. Inglewood, CA 90301
	Todd Walters President UFCW Local 135 2001 Camino Del Rio South San Diego, CA 92108
	Andrea Zinder President UFCW Local 324 8530 Stanton Ave., Box 5004 Buena Park, CA 90620

Agent for Service of Legal Process

The Trust Fund Administrator has been designated by the Trustees as the Agent for Service of Legal Process. Legal process may also be served on any Trustee.

Attn: Trust Fund Administrator
Southern California Drug Benefit Fund
2220 Hyperion Avenue
Los Angeles, CA 90027

Collective Bargaining Agreements

The Plan is maintained in accordance with Collective Bargaining Agreements between various Employers

in the Southern California Retail Drug Industry and Union Locals of the United Food & Commercial Workers International Union. Copies of the Collective Bargaining Agreements are available for examination at the Fund Office or at the office of your Union Local and may also be obtained upon written request to the Plan Administrator.

In addition, any Participant or beneficiary may, upon written request to the Trust Fund Administrator, obtain information as to whether or not a particular Union or employer is a party to the Plan and, if so, its address.

Plan Year

The Plan's fiscal records are kept on a 12-month basis beginning on July 1 and ending on June 30.

Plan's Requirements for Eligibility and Benefits

The Plan's requirements with respect to eligibility to participate in the Plan and to receive benefits, as well as circumstances that may result in disqualification, ineligibility, or denial or loss of benefits, are described in the "Eligibility Rules" and "Enrollment" Chapters of this booklet, the remaining Chapters of this booklet that describe Plan benefits, and the "Excluded Services and Limitations" Chapter of this booklet.

Funding Medium

Benefits are provided from the Fund's assets, which are accumulated under the provisions of the Collective Bargaining Agreements and the Trust Agreement and held in trust for the purpose of providing benefits to Participants and defraying reasonable administrative expenses. All self-funded benefits are provided directly through the Fund.

Contribution Source

The Plan is funded by contributions made under the provisions of Collective Bargaining Agreements and participation agreements between the Fund and participating Employers, which provide for contributions by the Employers to the Fund on an agreed-upon fixed rate per hour worked or paid, and by Employee premiums.

Discretionary Authority to Interpret Plan

In carrying out their responsibilities under the Plan, the Board of Trustees has full discretionary authority to interpret the terms of the Plan and to determine eligibility and entitlement to Plan benefits in accordance with the terms of the Plan. Any interpretation or determination made under that discretionary authority will be given full force and effect, unless it can be shown that the interpretation or determination was arbitrary and capricious.

Plan Amendments or Termination of the Plan

The Fund will remain in full force and effect so long as there are Employers who are obligated under Collective Bargaining Agreements to make contributions to the Fund. Subject to the applicable Collective Bargaining Agreements, the Board of Trustees reserves the right to modify, amend, or terminate this Plan, or any part of it, at any time.

Statement of ERISA Rights

As a Participant in the Southern California Drug Benefit Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Plan Participants shall be entitled to:

Receive Information About Your Plan and Benefits

1. Examine, without charge, at the Fund Office and also at the locations of the Local Union Insurance Offices, all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the

   U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

3. Receive a summary of the Plan's annual financial report. The Plan Administrator is required by law to furnish each Participant with a copy of this summary annual report.

Continue Group Health Plan Coverage

Continue health care coverage for yourself, Spouse, or Dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event, as described in the Chapter of this booklet entitled "COBRA & USERRA: Temporary Continuation of Health Coverage." You and/or your Dependents may have to pay for such coverage, if it is elected. Review this booklet and documents governing the Plan on the rules governing your COBRA Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising your rights under ERISA.

Enforce Your Rights

If your claim for a welfare benefit is denied or ignored, in whole or in part, you have a right to know why this was done, to obtain copies of documents relating to the decision without charge, and to appeal any denial, all within certain time schedules, as discussed in the "Claims and Appeals Procedures & the External Review Process" chapter of this document.

Under ERISA, there are steps you can take to enforce the above rights. For instance, if you request a copy of plan documents or the latest annual report from the Plan and do not receive them within 30 days, you may file suit in a Federal court. In such a case, the court may require the Plan Administrator to provide

the materials and pay you up to $110 a day until you receive the materials, unless the materials were not sent because of reasons beyond the control of the administrator.

If you have a claim for benefits that is denied or ignored, in whole or in part, you may file suit in a state or Federal court.

In addition, if you disagree with the Plan's decision or lack thereof concerning the qualified status of a medical child support order (QMCSO), you may file suit in Federal court.

If it should happen that plan fiduciaries misuse the Plan's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U. S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about your Plan, you should contact the Plan Administrator. If you have any questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Plan Administrator, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, DC 20210.

You may obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration toll-free at 1-866-444-EBSA (3272).

Statement of the Fund's Rights

A. The Fund makes no representation that employment with it or with a contributing Employer represents lifetime security or a guarantee of continued employment. Further, your eligibility or rights to benefits under the Fund should not be interpreted as a guarantee of employment.

B. The Board of Trustees, as the Plan Sponsor, intends that plan terms described in this document, including those relating to eligibility and benefits, be legally enforceable, and that each plan is maintained for the exclusive benefit of Participants, as defined by law. Notwithstanding the foregoing, certain benefits under the Plan are provided under the terms of separate plan documents. For each of these benefits, the separate plan document, which is summarized in this booklet, is legally binding and, in case of any conflict with the summary provided in this booklet, the provisions of the separate plan document shall control.

C. Any written or oral statement, other than a written statement signed by the Board of Trustees, that is contrary to the provisions of this booklet is invalid, and no prospective, active, or former Employee, Participant, or Dependent should rely on any such statement.

Right of Fund to Require a Physical Examination

The Fund reserves the right to have a person who is totally disabled or who has submitted a Claim for benefits and is undergoing treatment under the care of a Physician, to be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under the Fund. The cost of such an examination will be paid by the Fund.

Information You or Your Dependents Must Furnish to the Fund

In addition to information you must furnish in support of any Claim for benefits under the Fund, you or your covered Dependents must furnish information you or they may have that may affect eligibility for Fund coverage.

Failure to give the Fund a timely notice (as noted above) may (1) cause your Spouse and/or Child(ren) to lose their right to obtain COBRA Coverage, (2) cause your Child's coverage to end when it otherwise might continue because of a disability, (3) cause the inability to process Claims until eligibility issues have been resolved, and/or (4) result in a Participant's liability to the Fund if any benefits are provided to an ineligible person.

Privacy and Your Protected Health Information

A law, known as the Health Insurance Portability and Accountability Act of 1996 (HIPAA) gives you certain rights with respect to your health information. It is required that the Fund maintain the privacy of your Protected Health Information (PHI) in accordance with HIPAA.

The Fund maintains a HIPAA Notice of Privacy Practices which describes how the Fund will use and maintain the PHI of Participants. The Fund Office will provide you a copy of the Fund's HIPAA Notice of Privacy Practices upon request, as required by the HIPAA Privacy Rule.

Please address your request to:

Privacy Officer
Southern California Drug Benefit Fund
2220 Hyperion Avenue
Los Angeles, CA 90027
Phone: (323) 666-8910 Ext. 201
(877) 999-8329 Ext. 201

XVII
DEFINITIONS

Whenever the following capitalized words or terms are used in this booklet, they have the meanings shown below. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Air Ambulance: Medical transport of a patient by a rotary wing air ambulance, as defined in 42 CFR 414.605, or fixed wing air ambulance, as defined in 42 CFR 414.605.

Allowed Amount: The amount allowed under the Indemnity Medical Plan for covered services or supplies. The Allowed Amount, as determined by the Plan Administrator or its Designee, is the lesser of the Provider's actual billed charge or:

1. For a PPO Provider, the Contract Rate for the service or supply.
2. For a Non-PPO Provider, the dollar amount the Fund has determined it will allow for the service or supply.

Ambulatory Surgery Center (also referred to as Ambulatory Surgery Facility or Outpatient Surgery Center): A specialized facility that is established, equipped, operated, and staffed primarily for the purpose of performing outpatient surgical procedures and that meets one of the following two tests:

1. It is licensed as an Ambulatory Surgery Facility or Outpatient Surgery Center by the regulatory authority responsible for the licensing under the laws of the jurisdiction in which it is located; or
2. Where licensing is not required, it meets all of the following requirements:
    a. Is operated under the supervision of a licensed Physician who is devoting full time to supervision and permits a surgical procedure to be performed only by a duly qualified Physician who, at the time the procedure is performed, is privileged to perform the procedure in at least one Hospital in the area.
    b. Requires in all cases, except those requiring only local infiltration anesthetics, that a licensed anesthesiologist administer the anesthetic or supervise an anesthetist who is administering the anesthetic, and that the anesthesiologist or anesthetist remain present throughout the surgical procedure.
    c. Provides at least one operating room and at least one post-anesthesia recovery room.
    d. Is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
    e. Has trained personnel and necessary equipment to handle emergency situations.
    f. Has immediate access to a blood bank or blood supplies.
    g. Provides the full-time services of one or more registered nurses (RNs) for patient care in the operating rooms and in the post-anesthesia recovery room.
    h. Maintains an adequate medical record for each patient, which contains an admitting diagnosis (including, for all patients except those undergoing a procedure under local anesthesia, a preoperative examination report, medical history, and laboratory tests and/or x-rays), an operative report and a discharge summary.

Balance Billed or Balance Billing: A bill from a Provider to a patient for the difference (or balance) between the Allowed Amount under the Indemnity Medical Plan and what the Provider actually charged (i.e., the billed charges).

Behavioral Health Disorder (also referred to as mental health and/or substance use disorders): A Behavioral Health Disorder is any illness that is defined within the mental disorders section of the current edition of the International Classification of Diseases (ICD) manual or is identified in the current edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM), including a psychological and/or physiological dependence on or addiction to alcohol, psychiatric drugs, medications, or other substances of abuse, regardless of any underlying physical or organic cause.

Board of Trustees (also referred to as the Board or the Trustees): The Board of Trustees of the Southern California Drug Benefit Fund.

Claim: A request for benefits as defined in and submitted in accordance with the claims and appeals procedures described in the Chapter of this booklet entitled "Claims and Appeals Procedure & the External Review Process."

Coinsurance: A Participant's share of the costs of a covered health care service, calculated as a percentage of the Contract Rate or the Allowed Amount for the service.

Collective Bargaining Agreement: The current agreements between various Employers in the Southern California Retail Drug Industry or the Health Care Delivery Industry and Union Locals of the United Food and Commercial Workers International Union which provide for contributions to this Fund, in accordance with the provisions of the Trust Agreement, for Gold and/or Platinum Plan benefits.

Contract Rate: The negotiated fee that a PPO Provider has agreed to accept for a covered service or supply provided to a Participants in the Indemnity Medical Plan.

Copayment (also referred to as Copay): A fixed dollar amount that a Participant must pay for a covered health care service, usually when the service is received.

Cosmetic Surgery or Treatment: Surgery or medical treatment performed solely or primarily to improve or preserve appearance, but not physical function. Cosmetic Surgery or Treatment includes, but is not limited to, removal of tattoos, breast augmentation, or other medical/surgical treatment, Prescription Drugs, and dental treatment intended to restore or improve physical appearance, as determined by the Plan Administrator or its designee. Restorative surgery performed during or following mutilative surgery, which is required as a result of illness or injury (such as breast reconstruction following a mastectomy), is not considered Cosmetic Surgery.

Cost Sharing: The share of costs for covered health care services that a Participant must pay out of their own pocket (sometimes called "out-of-pocket costs"). Some examples of Cost Sharing are Copayments, Deductibles, and Coinsurance. Other costs of health care services or coverage borne by Participants, including premiums, penalties, balance-billed amounts, or the cost of noncovered care, are generally not considered Cost Sharing.

Covered Charges: The amount that an HMO Plan has determined to be an appropriate charge for the service provided.

Covered Expenses: Covered Expenses are limited to expenses for medical services and supplies under the Indemnity Medical Plan that are:

1. **Medically Necessary**; and
2. **Not in excess of the Allowed Amount** (for services from a Non-PPO Provider) **or the Contract Rate** (for services from a PPO Provider); and
3. **Not excluded from coverage** (as provided in the "Excluded Services and Limitations" Chapter of this booklet); and
4. **Not in excess of a benefit maximum** (as shown in the Schedule of Medical Benefits for the Indemnity Medical Plan); and
5. **For the diagnosis or treatment of an Injury or Illness** (except when specifically covered under the Plan, such as Preventive Care Services); and
6. Provided or ordered by a Physician or other Health Care Provider; and
7. **Incurred while the Participant has coverage under the Plan.**

Generally, the Fund does not reimburse all of your Covered Expenses. Usually, you will have to satisfy a Deductible and pay Copayments and/or Coinsurance toward your Covered Expenses.

Covered Employment: Employment of an Employee by an Employer for which the Employer is obligated to contribute to the Fund under the terms of a Collective Bargaining Agreement.

Custodial Care: Care or services that are provided to help a person to perform activities of daily living, including personal hygiene, which can be safely performed by individuals who are not licensed health care professionals. Custodial Services include personal care, homemaking services, moving the patient, acting as companion or sitter, or supervising medication which can usually be self-administered. Services are custodial regardless of who recommends, orders, provides, or directs the care or the location for the care.

Deductible: The annual amount a Participant owes for health care or dental services before the Fund will pay benefits that are subject to the Deductible.

Dependent: Dependents who can be enrolled in the Fund's health care coverage are described in Section 4 ("Dependent Coverage") of the Chapter of this booklet entitled "Eligibility Rules."

Domestic Partner: A person with whom you have a legal Domestic Partnership recognized by the State of California.

Drug Pension Plan: The Southern California United Food and Commercial Workers Unions and Drug Employers Pension Plan.

Dual Coverage: Coverage under the Indemnity Medical Plan both as an Employee and as the Dependent of another covered Employee or as the Dependent of two covered Employees, where both covered Employees have elected family coverage.

Durable Medical Equipment: Equipment that can withstand repeated use, is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness, is not disposable or non-durable, and is appropriate for the patient's home. Durable Medical Equipment includes, but is not limited to, apnea monitors, blood sugar monitors, electric Hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Emergency: The unexpected onset of a medical condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in placing the health of the individual (or in the case of a pregnant woman, the health of her unborn Child) in serious jeopardy, serious impairment to bodily functions, or serious dysfunction/impairment of any bodily organ or part. In the event of a Behavioral Health Disorder, the lack of the treatment could reasonably be expected to result in the patient harming himself or herself and/or other persons.

Emergency Medical Condition: A medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in serious impairment to bodily functions, serious dysfunction of any bodily organ or part, or placing the patient's health (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.

Emergency Services:

(a) With respect to an Emergency Medical Condition, Emergency Services means an appropriate medical screening examination that is within the capability of the emergency department of a Hospital or an Independent Freestanding Emergency Department, as applicable, including ancillary services routinely available to the emergency department to evaluate such Emergency Medical Condition, along with such further medical examination and treatment as are required to stabilize the patient (regardless of the department of the Hospital in which such further examination or treatment is furnished).

(b) Emergency Services also includes services otherwise covered by the Indemnity Medical Plan that are furnished by an Out-Of-Network Health Care Professional or an Out-Of-Network Emergency Facility (regardless of the department of the Hospital in which such items or services are furnished) after the patient is stabilized and as part of outpatient observation or an inpatient or outpatient stay with respect to the visit in which initial services were provided for an Emergency Medical Condition, unless (1) the patient is able to travel using nonmedical transportation or nonemergency medical transportation to an available Network Provider or Facility within a reasonable travel distance (as determined by the attending emergency Physician or treating Health Care Professional), (2) the patient or the patient's authorized representative gives the Out-Of-Network Provider informed written consent to give up Cost Sharing and Balance Billing protections for these services, and (3) the Provider or Facility satisfies any additional requirements or prohibitions of the No Surprises Act or regulations issued thereunder.

(c) For purposes of paragraphs (a) and (b), the term "to stabilize" means, with respect to an Emergency Medical Condition, to provide such medical treatment of the condition as may be necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the individual from a facility (or, with respect to an Emergency Medical Condition involving a pregnant woman who is having contractions, to deliver a newborn child, including the placenta).

Employee: Any person who works in Covered Employment.

Employer or Contributing Employer: An employer that is required to make contributions to the Fund on behalf of Employees under the terms of a Collective Bargaining Agreement.

"Experimental" or **"Investigational"** means any of the following**:**

1. Any medical procedure, equipment, treatment or course of treatment, drug, or medicine which is not normally and regularly used or prescribed by the medical community of Southern California for the reason that it remains under clinical or laboratory investigation or has not been exposed to clinical or laboratory investigation;
2. Any drug, device, or medical treatment or procedure which is the subject of on-going phase I, II or III clinical trials or under study to determine its maximum tolerated dose, its toxicity, its safety, its efficacy, or its efficacy as compared with the standard means of treatment or diagnosis; or
3. If Reliable Evidence shows that the consensus among experts regarding the drug, device, or medical treatment or procedure 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 the standard means of treatment or diagnosis.

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

The Trustees may rely on the advice of medical consultants in determining whether a service or supply is "Experimental" or "Investigational" under this definition.

Food and Drug Administration (FDA): The U.S. government agency responsible for administration of the Food, Drug and Cosmetic Act and whose approval is required for certain Prescription Drugs and other medical services and supplies to be lawfully marketed.

Full-Time Student: A Child between the ages of 19 and 24 who is registered at an accredited educational institution or technical or trade school on a full-time basis.

Fund: The Southern California Drug Benefit Fund.

Fund Office: The administrative office of the Fund.

General Sales Pension Plan: The Southern California General Sales Employers and United Food and Commercial Workers Unions Pension Plan.

Health Care Facility: For non-Emergency Services, each of the following: (i) A hospital (as defined in section 1861(e) of the Social Security Act); (ii) a Hospital outpatient department; (iii) a critical access Hospital (as defined in section 1861(mm)(1) of the Social Security Act); and (iv) an ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

Health Care Provider: An individual who is legally licensed and/or legally authorized to practice or provide certain health care services under the laws of the state or jurisdiction where the services are rendered and acts within the scope of his or her license and/or authority. For example, this may include a Physician, a physician's assistant, an anesthesiologist, a stand-by physician or a midwife, or a pharmacist in California acting within the scope of his/her license and/or authority.

Home Health Care: Health care services and supplies that a patient receives in their home under their doctor's orders. Services may be provided by nurses, therapists, social workers, or other licensed Health Care Providers. Home Health Care typically does not include help with non-medical tasks, such as cooking, cleaning, or driving.

Home Health Care Agency: An agency or organization that provides a program of Home Health Care and meets one of the following three tests:

1. It is approved by Medicare and/or accredited by The Joint Commission (TJC);
2. It is licensed as a Home Health Care Agency by the regulatory authority having responsibility for the licensing under the laws of the jurisdiction in which it is located; or
3. If licensing is not required, it meets all of the following requirements:
    a. Has the primary purpose of providing a Home Health Care delivery system bringing supportive skilled nursing and other therapeutic services under the supervision of a Physician or registered nurse (RN) to the home.
    b. Has a full-time administrator.
    c. Is run according to rules established by a group of professional Health Care Providers including Physicians and RNs.
    d. Maintains written clinical records of services provided to all patients.
    e. Its staff includes at least one RN or it has nursing care by an RN available.
    f. Its Employees are bonded.
    g. Maintains malpractice insurance coverage.

Hospice: An agency or organization providing a specialized form of interdisciplinary health care that provides palliative care (pain control and symptom relief) and alleviates the physical, emotional, social, and spiritual discomforts of a terminally ill person, as well as providing supportive care to the primary caregiver and patient's family.

Hospice Care: Medically Necessary care and treatment for a patient who has six months or less to live due to a terminal Illness or Injury as certified by a Physician.

Hospice Facility: A facility that has been licensed as a Hospice pursuant to State Laws or a licensed Home Health Agency with federal Medicare certification pursuant to California Health and Safety Code Sections 1726 and 1747.1.

Hospital: A Health Care Facility that is a public or private facility or institution, licensed and operating as a Hospital in accordance with the laws of the appropriate legally authorized agency, which:

1. Provides care and treatment by Physicians and Nurses on a 24-hour basis for Illness or Injury through the medical, surgical, and diagnostic facilities on its premises;
2. Provides diagnosis and treatment on an inpatient basis for compensation; and
3. Is approved by Medicare as a Hospital.

The facility may also be accredited as a Hospital by The Joint Commission (TJC). A Hospital may include facilities for behavioral health treatment that are licensed and operated according to law.

Illness: Any bodily sickness or disease, including any Behavioral Health Disorder or any congenital abnormality of a newborn Child, as diagnosed by a Physician and as compared to the person's previous condition. Pregnancy of an Employee or covered Spouse will be considered an Illness only for the purpose of coverage under this Plan. However, infertility is not an Illness under this Plan.

Independent Freestanding Emergency Department: A health care facility (not limited to those described in the definition of Health Care Facility, above) that is geographically separate and distinct from a Hospital under applicable State law and provides Emergency Services.

Independent Review Organization (IRO): An entity accredited by the Utilization Review Accreditation Commission (URAC) or by a similar nationally recognized accrediting organization that conducts independent external reviews under the Fund's External Review Process.

Initial Eligibility Date: The earliest date an Employee becomes eligible for coverage under the Fund in accordance with the Chapter of this booklet entitled "Eligibility Rules."

Injury: Any damage to a body part resulting from trauma from an external source.

Medically Necessary: Procedures, treatments, supplies, devices, equipment, facilities, or drugs (all services) that a Physician or other Health Care Provider, exercising prudent clinical judgment, would provide to a patient for the purpose of evaluating, diagnosing, or treating an Illness, Injury, or disease or its symptoms, and that are:

1. In accordance with generally accepted standards of medical practice; and
2. Clinically appropriate in terms of type, frequency, extent, site and duration, and considered effective for the patient's Illness, Injury, or disease; and
3. Not primarily for the convenience of the patient, Physician, or other Health Care Provider; and
4. Not experimental, educational, or unproven (investigational); and
5. Not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's Illness, Injury, or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, National Physician Specialty Society recommendations, the views of medical practitioners practicing in relevant clinical areas, and any other relevant factors.

Medicare: The Health Insurance for the Aged and Disabled provisions in Title XVIII of the U.S. Social Security Act, as it is now amended and as it may be amended in the future.

Non-PPO: Not in the Plan's PPO network. Also referred to as Out-of-Network.

Non-PPO Provider: A Provider who does not participate in the Plan's network of providers (is not a PPO Provider). Also referred to as an Out-of-Network Provider.

NSA: The federal No Surprises Act, which was signed into law in December 2020.

NSA Services: Medical services and items provided by Non-PPO Providers that are subject to the Cost Sharing and Balance Billing protections of the No Surprises Act.

Open Enrollment: The period during which an eligible Employee may enroll or disenroll, add or drop Dependents, or select among the health benefit programs that are available from the Fund. Open Enrollment is generally held in the fall with enrollment changes effective the following January 1st.

Orthopedic Appliance: An appliance worn on the body specifically concerned with the preservation and restoration of the function of the skeletal system, its articulations, and associated structures. For purposes of the Indemnity Medical Plan, this definition does not include dental orthotics.

Out-of-Area Benefits: Benefits provided under the Indemnity Medical Plan for Out-of-Area Services.

Out-of-Area Services: Medically Necessary services received from a Non-PPO Provider if there is no PPO Provider available to provide the service within 50 miles of your home.

Out-of-Pocket Maximum (OOP Max): A limit on the amount of Covered Expenses for PPO services and supplies that a Participant will have to pay out of their own pocket in a calendar year, as described in Section 9 ("The Medical Out-of-Pocket Maximum") of the Chapter of this booklet entitled "The Indemnity Medical Plan."

Outpatient Surgery Center: See the definition for Ambulatory Surgery Center.

Participant: Any person eligible for benefits under the Plan, whether as an Employee or as the Dependent of an Employee, who has completed all requirements for enrollment and coverage under the Plan and is actually covered by the Plan.

Participating Pharmacy: Those pharmacies listed in the Fund's Participating Pharmacy Directory. The Fund's Participating Pharmacy Directory is updated from time to time and is available on the Fund's website or from the Fund Office.

Physician: A person who: (1) is legally licensed as a Medical Doctor (MD), Doctor of Osteopathy (DO), or Doctor of Podiatric Medicine (DPM); (2) is authorized to practice medicine, to perform surgery, and to administer drugs under the laws of the state or jurisdiction where the services are rendered; (3) acts within the scope of his or her license; and (4) is not the patient.

Plan: The employee welfare benefit plans (including the group health plan) provided by the Southern California Drug Benefit Fund.

Plan Administrator: The Board of Trustees of the Southern California Drug Benefit Fund.

Podiatrist: A person who (1) is legally licensed as a Doctor of Podiatric Medicine (DPM); (2) is authorized to provide care and treatment of the human foot (and in some states, the ankle and leg up to the knee) under the laws of the state or jurisdiction where the services are rendered; (3) acts within the scope of his or her license; and (4) is not the patient.

PPO: A Preferred Provider Organization (PPO) is an organization that has contracted with Providers to form a network of Providers who agree to provide services to the Fund's Participants at negotiated rates and who agree on other terms and conditions of the PPO contract. Also referred to as In-Network.

PPO Provider: A Provider who has contracted with Anthem Blue Cross of California or BlueCard to provide services to Fund Participants at negotiated rates and who agree to other terms and conditions of the PPO contract. Also referred to as an In-Network Provider.

Preauthorization: A review performed by Anthem, Optum Rx, or the Fund Office before services are rendered, to determine whether the service, admission, and/or length of stay in a Health Care Facility is appropriate and Medically Necessary.

Prescription Drugs: For the purposes of this Plan, Prescription Drugs include:

1. **Federal Legend Drug:** Any medicinal substance that the Federal Food, Drug and Cosmetic Act requires to be labeled, "Caution — Federal Law prohibits dispensing without prescription."
2. **Compound Drug**: Any drug that has more than one ingredient, at least one of which is a Federal Legend Drug or a drug that requires a prescription under state law.
3. **Brand Name Drug:** Any drug that has been approved by the U.S. Food and Drug Administration (FDA) and that has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. A Brand Name Drug cannot have competition from a Generic Drug until after the patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic Drug**: Any generic version, or copy, of an FDA-approved Brand Name Drug that contains the same active ingredients as the Brand Name Drug and is the same in terms of dosage, safety, purity, strength, how it is taken, quality, performance, and intended use. Generic Drugs are approved by the FDA.

Preventive Care Services: Services and supplies, including immunizations, that are covered by the Indemnity Medical Plan at 100% without Cost Sharing (i.e., without Deductibles, Copays, or Coinsurance) when provided by In-Network Providers (i.e., PPO Providers). Preventive Care Services are subject to treatment, setting, frequency, and medical management criteria, which must be satisfied in order to be covered by the Plan at 100%. For a description of the Preventive Care Services that are covered by the Plan at 100% when you use a PPO Provider, see the current Indemnity PPO Medical Plan Preventive Care Guidelines, which are updated on an annual basis.

Provider: A Health Care Provider or a Health Care Facility (both defined above) that is licensed, certified, or accredited in accordance with the requirements of state law.

Qualifying Hours: An average of 23 or more straight-time hours worked in Covered Employment for each whole week in the Employer's reporting period (Work Month). For more information, see the "Eligibility Rules" Chapter of this booklet.

Qualifying Payment Amount (QPA): With respect to NSA Services, the cost calculated in accordance with the No Surprises Act, using the methodology adopted by the Board of Trustees.

Recognized Amount: The Recognized Amount is determined under the No Surprises Act. For the Indemnity Medical Plan, the Recognized Amount is generally the lesser of the Provider's billed charges or the Qualifying Payment Amount (QPA).

Rescission of Coverage: A Rescission of Coverage is a cancellation or discontinuance of coverage that has a retroactive effect, unless it is attributable to a failure to timely pay required premiums or contributions towards the cost of coverage. A Rescission of Coverage can occur even if it has no adverse effect on any particular benefit at that time. The Fund is permitted to rescind your coverage upon 30 days' advance written notice if you perform an act, practice or omission that constitutes fraud or you make an intentional misrepresentation of material fact that is prohibited by the terms of the Plan.

Retroactive termination of an ex-spouse's coverage due to the failure to timely notify the Fund Office of a divorce is not considered a Rescission of Coverage.

Skilled Nursing Facility (SNF): A public or private facility that: is licensed and operated according to law; primarily provides skilled nursing and related services to people who require medical or nursing care; rehabilitates injured, disabled, or sick people; and meets all the following requirements:

1. It is accredited by The Joint Commission (TJC) as a Skilled Nursing Facility or is recognized by Medicare as a Skilled Nursing Facility; and
2. It is regularly engaged in providing room and board and continuously provides 24 hour-a-day skilled nursing care to sick and injured persons at the patient's expense during the convalescent stage of an Injury or Illness, maintains on its premises all facilities necessary for medical care and treatment, and is authorized to administer medication to patients on the order of a licensed Physician; and
3. It provides services under the supervision of Physicians; and
4. It provides nursing services by or under the supervision of a licensed Registered Nurse (RN), with at least one RN on duty at all times; and
5. It maintains a daily medical record of each patient who is under the care of a licensed Physician; and
6. It is not (other than incidentally) a home for maternity care, rest, domiciliary (non-skilled/custodial) care, or care of people who are aged, alcoholic, blind, deaf, drug addicts, mentally deficient, or mentally ill; and
7. It is not a hotel or motel.

A Skilled Nursing Facility that is part of a Hospital (as defined above) will be considered a Skilled Nursing Facility under the Indemnity Medical Plan.

Spouse: An individual who is legally married to an Employee, as recognized under the laws of the state or jurisdiction in which the marriage was entered.

State: The state of California.

Supplementary Plan: The Fund's Supplementary Disability and Unemployment Plan (Amended and Restated as of March 1, 2016).

Trust Agreement: The Restated Declaration of Trust Providing for the Establishment and Maintenance of the Southern California Drug Benefit Fund.

Trustees: See the definition of Board of Trustees.

Union or Union Local: Any one of the United Food & Commercial Workers Union Locals 8, 135, 324, 770, 1167, 1428, or 1442.

Work Month: An Employer's monthly reporting period to the Fund (sometimes known as the monthly "payroll period"), as described in Section 1("Initial Eligibility") of the Chapter of this booklet entitled "Eligibility Rules.

Appendix: Special Initial Eligibility Rules

In this Appendix, the terms "you" and "your" refer to the Employee.

The Fund's special rules for initial eligibility may apply to you if:

- You are transferred by your Employer into a position that is covered by this Fund;
- You were working in employment covered by another UFCW Fund in California immediately before beginning Covered Employment (Reciprocity);
- You are employed in a new store or a newly organized store of an existing Employer; or
- You work for a newly organized Employer.

If you think one of the first two Special Initial Eligibility Rules apply to you ("Transfers into Bargaining Unit with the Same Employer" or "Transfers from Other UFCW Trust Funds in California (Reciprocity)"), **you must notify the Fund Office within 60 days after the date you begin work in Covered Employment**. Otherwise, you will earn eligibility under the "General Eligibility Rules for New Employees" (described in Section 1.A of the "Eligibility Rules" Chapter of this booklet). For the other two Special Initial Eligibility Rules ("New Stores/Newly Organized Stores of Existing Employer" or "New Employers (When a Collective Bargaining Agreement Is First Effective)"), your Employer will notify the Fund Office for you.

If none of these four Special Initial Eligibility Rules listed above apply to you, you will earn eligibility under the "General Initial Eligibility Rules for New Employees" (described in Section 1.A of the "Eligibility Rules" Chapter of this booklet).

1. <u>Transfers into Bargaining Unit with the Same Employer</u>

If your Employer transfers you to a position in Covered Employment from outside of the bargaining unit, without an intervening quit or termination of employment, **and you notify the Fund Office of your transfer within 60 days after the date you begin work in Covered Employment,** you will become eligible for coverage as follows:

a. If you had medical coverage from a different health plan sponsored by your Employer immediately before your transfer to Covered Employment, you and your Dependents will become eligible for all benefits on your Initial Eligibility Date, which is the later of: (i) the first day of the first month after your transfer to Covered Employment; or (ii) the first day of the first month after your coverage from your other Employer-provided health plan ends.

b. If you did not have medical coverage from another health plan sponsored by your Employer at the time you transferred to Covered Employment, you and your Dependents will become eligible for all benefits when you become eligible for coverage under the "General Initial Eligibility Rules for New Employees" (see Section 1.A of the "Eligibility Rules" Chapter of this booklet), but the time you worked for your Employer before your transfer will count in determining your Initial Eligibility Date. (Your Initial Eligibility Date cannot be earlier than the first day of the first month after you begin working in Covered Employment).

When you are eligible to enroll in an HMO Plan: If you had HMO coverage under your pre-transfer Employer-provided plan, you may enroll in a Fund HMO plan as of your Initial Eligibility Date.

Otherwise, you may enroll in an HMO Plan when you have reached the fourth annual Open Enrollment after entering Covered Employment. However, your time worked for the Employer prior to your transfer into Covered Employment under this Fund will count in determining whether you have reached the fourth annual Open Enrollment after your most recent date of hire.

2. Transfers from Other UFCW Trust Funds in California (Reciprocity)

If you worked under the jurisdiction of another UFCW trust fund in California and begin Covered Employment under this Fund within 60 days from your termination of employment under the other UFCW trust fund, you and your Dependents will become eligible for all benefits as follows, as long as you notify the Fund Office of your transfer within 60 days after the date you begin work under this Fund:

a. If you were eligible for medical coverage from the other UFCW trust fund in California when you began Covered Employment, you and your Dependents will become eligible for all benefits on the later of: (i) the first day of the first month after you begin work in Covered Employment; or (ii) the first day of the first month after your coverage under the other UFCW trust fund ends. You must then work Qualifying Hours in this Fund beginning with the month in which you transfer employment or the month immediately following your transfer.

b. If you did not have medical coverage from the other trust fund in California when you began Covered Employment, you and your Dependents will become eligible for coverage from this Fund in accordance with the "General Initial Eligibility Rules for New Employees" (see Section 1.A of the "Eligibility Rules" Chapter of this booklet). However, the time you worked under the other trust fund (before your transfer) plus your work in Covered Employment will be counted to meet the initial eligibility requirements under the "General Initial Eligibility Rules for New Employees." You cannot become eligible for benefits from this Fund any earlier than you would have become eligible had all your hours under the other trust fund been Covered Employment, nor can you become eligible for benefits from this Fund earlier than the first day of the first month after you begin Covered Employment.

When you are eligible to enroll in an HMO Plan: You may enroll in an HMO Plan when you have reached the fourth annual Open Enrollment after entering Covered Employment. However, your time worked under the other UFCW trust fund prior to your transfer into Covered Employment under this Fund will count in determining whether you have reached the fourth annual Open Enrollment after your most recent date of hire.

3. New Stores/Newly Organized Stores of Existing Employer

The Fund has special eligibility rules that apply to Employees of a new store or a newly organized store of an Employer already under a Collective Bargaining Agreement.

a. If you are on the payroll of the Employer on the date the Collective Bargaining Agreement first becomes effective for the store, and you worked Qualifying Hours in the month immediately preceding the effective date of the Collective Bargaining Agreement, you and your Dependents will become eligible for all benefits on the later of: (i) the first day of the first month coincident with or immediately following the date the Collective Bargaining

Agreement becomes effective for that location; or (ii) the first day of the first month after your coverage from your other Employer-provided health plan ends.

b. If you did not work Qualifying Hours in the Work Month immediately preceding the effective date of the Collective Bargaining Agreement for the store, you and your Dependents must establish initial eligibility under the "General Initial Eligibility Rules for New Employees" (see Section 1.A of the "Eligibility Rules" Chapter of this booklet).

When you are eligible to enroll in an HMO Plan: You may enroll in an HMO Plan as of your Initial Eligibility Date.

4. New Employers (When a Collective Bargaining Agreement Is First Effective)

a. If you are on the payroll of a newly organized Employer on the date the new Employer's Collective Bargaining Agreement first becomes effective, and you worked Qualifying Hours for the new Employer in the month (or other period approved by the Trustees) immediately preceding the effective date of the Employer's Collective Bargaining Agreement, you will become eligible for Employee-only medical coverage on the first day of the first calendar month coincident with or immediately following the effective date of the new Employer's Collective Bargaining Agreement. Thereafter, you will earn eligibility for prescription drug, Dependent, and dental coverage in accordance with the "General Initial Eligibility Rules for New Employees" (see Section 1.A of the "Eligibility Rules" Chapter of this booklet).

b. If you did not work Qualifying Hours in the month (or other period approved by the Trustees) immediately preceding the effective date of the new Employer's Collective Bargaining Agreement, you and your Dependents must establish initial eligibility under the "General Initial Eligibility Rules for New Employees" (see Section 1.A of the "Eligibility Rules" Chapter of this booklet).

When you are eligible to enroll in an HMO Plan: You may enroll in an HMO Plan when you have reached the fourth annual Open Enrollment after entering Covered Employment.