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United Food & Commercial Workers Unions and Food Employers Benefit Fund

Summary Plan Description & Plan Document for Plan A

Effective August 1, 2019

Describing Benefits for Active Employees and Dependents in Plan A

This Summary Plan Description is for Participants in Plan A

This Summary Plan Description (SPD) and Plan Document describes benefits for all Plan A benefit levels. Specifically, it describes benefits for Participants in the following plans:

- Plan A Platinum Plus
- Plan A Platinum
- Plan A Gold
- Plan A Silver

How to determine if you are in Plan A: You are a Plan A Employee, and will earn eligibility for coverage under Plan A, if you work in Covered Employment for an Employer that contributes to the Fund for Plan A benefits.

This SPD does not describe benefits for Participants in Plan B. There is a separate SPD that describes benefits for all Plan B benefit levels (Plan B Platinum Plus, Plan B Platinum, Plan B Gold and Plan B Silver).

To determine whether you are eligible for benefits or to determine whether you are in Plan A or Plan B, please call the Fund Office.

United Food & Commercial Workers Unions and Food Employers Benefit Fund
6425 Katella Avenue, Cypress, CA 90630-5238
714-220-2297, 562-408-2715, 877-284-2320
scufcwfunds.com

United Food & Commercial Workers Unions and Food Employers Benefit Fund
6425 Katella Avenue, Cypress, California 90630
Phone: 714-220-2297 • Fax: 714-236-9372
scufcwfunds.com

The Fund's Website Now Has a Valuable Tool: Your Benefits Plus Portal

Plan Participants have a valuable resource: the personalized **Benefits Plus Portal**. Through a smartphone, tablet or computer, plan participants can:

- **Update** their email address, phone number and address
- **View** their personalized benefits dashboard
- **Find** their benefit eligibility status and history
- **Confirm** dependents' information is current and accurate
- **Stay on top** of benefits announcements, deadlines and key documents
- **Track** recent (within 18 months) medical claims processed by the Fund Office

You can access the portal at **scufcwfunds.com/portal**.

Important Reminder

Make sure you keep the Fund Office informed of any changes to your address. You can notify the Fund of a change of address by logging into your portal account on the Fund's website at **scufcwfunds.com/portal** or you may contact the Fund Office.

It's Easy to Create Your Benefits Plus Account

Step 1: Go to **scufcwfunds.com/portal**

Step 2: Enter your name, email, date of birth, last 4 digits of your SSN, phone number

Step 3: Click "Create Account"

Step 4: Check your email—you'll get a link to finish creating your account profile.

Step 5: Establish your account username and password and set up security questions in case you forget your password in the future.

Step 6: You're in!

Need Help Registering?

Call the Help Desk at 877-284-0682. For benefits questions contact the Fund Office at 714-220-2297.

Asistencia en Español (Spanish Language Assistance)

Este documento contiene una breve descripción sobre sus derechos de beneficios del plan, en Inglés. Si usted tiene dificultad en comprender cualquier parte de esta información, favor de ponerse en contacto con la Oficina del Fondo en la dirección y/o número de teléfono ubicado en la tabla de referencia (Quick Reference Chart) de este documento.

Table of Contents

United Food & Commercial Workers Unions and Food Employers Benefit Fund

Summary Plan Description and Plan Document

For Plan A

Platinum Plus, Platinum, Gold and Silver Plans

Introduction

The Board of Trustees is pleased to provide you with this Summary Plan Description and Plan Document for Plan A benefits provided by the United Food & Commercial Workers Unions and Food Employers Benefit Fund (Fund or Benefit Fund).

This booklet is the Summary Plan Description (SPD) for the Plan A Health Plan. Together with the Restated Agreement and Declaration of Trust Providing for Establishment of the United Food and Commercial Workers Unions and Food Employers Benefit Fund (Trust Agreement), and other referenced documents, it is also the Plan Document. We have prepared this booklet as of August 1, 2019, to serve as a guide and reference concerning your health care benefits and how to use them.

This book describes the benefits, exclusions and limitations of the Plan A Health Care Plan, which provides medical benefits; including hospital benefits, prescription drugs, the health reimbursement account (for Indemnity PPO Medical Plan enrollees), dental, orthodontic and vision benefits. The Fund also provides death and accidental death and dismemberment benefits.

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

The Board of Trustees has 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 those benefits and eligibility rules. Any interpretations or opinions given by Employees of the Fund Office or Union Locals are not binding upon the Board of Trustees and cannot enlarge or change such benefits and eligibility rules.

The benefits described in this booklet are not vested, and may be modified, amended or terminated at anytime by the Board of Trustees in accordance with the Retail Food, Meat, Bakery, Candy, and General Merchandise Agreement between the major Food Employers and the Unions Locals.

This SPD/Plan Document is effective August 1, 2019, and replaces and supersedes all other plan documents, Summary Plan Descriptions (SPDs) and Summary of Material Modifications (SMMs) previously provided to Plan Participants.

This SPD/Plan Document may be amended from time to time. You will be sent a SMM explaining the changes that result from any amendment. If an SMM describes a benefit or procedure that is different from what is described here, you should rely on the SMM. Be sure to keep this document, along with SMMs or other notices of any Plan changes, in a safe and convenient place where you and your family can find and refer to them.

Important Information

- To verify that you are in Plan A, determine whether you are eligible for benefits, or for help in determining which level you are in (Platinum Plus, Platinum, Gold or Silver) please call the Fund Office at 714-220-2297.
- Coverage for your eligible Dependents is conditioned on you enrolling your Dependents and providing proof of Dependent status, satisfactory to the Plan, in addition to satisfying the other eligibility requirements of the Plan.
- It is very important to keep your contact information current with the Fund Office so that you receive important notices and other information from the Fund.
- Note that your eligibility or right to benefits under this Plan should not be interpreted as a guarantee of employment.

Questions You May Have

If you have any questions concerning eligibility or the benefits that you or your family are eligible to receive, please contact the Fund Office at the phone number and address located on the Quick Reference Chart on the next page. As a courtesy to you, the Fund Office staff may speak to you about your questions in person or by telephone; however, spoken communications are not binding on the Plan and cannot be relied upon in any dispute concerning your benefits.

In the event of any discrepancy between any information that you receive from the Fund Office or the Fund's satellite office in your Union Local, orally or in writing, and the terms of this document, the terms of this document will govern your entitlement to benefits, if any.

Important Notice

You or your Dependents must promptly furnish to the Fund Office information regarding change of name or address, marriage, divorce, death of any covered family member, change in Domestic Partnership status, change in status of a Dependent Child, Medicare enrollment or disenrollment, or the existence of other employer sponsored group coverage.

For Help or Information: When you need information, please check this document first. If you need further help, call the people listed in the following Quick Reference Chart. Note that the providers 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.

Quick Reference Chart

Information Needed	Whom to Contact
Fund Office — contact the Fund Office for help with: • PPO medical, dental and vision claims and appeals • Ancillary benefits for the HMOs (chiropractic services, acupuncture/acupressure, vision benefits and certain injectable drugs) • Eligibility status and updates • Open Enrollment or Special Enrollment • Dependent eligibility updates and changes • ID cards • Plan benefit information • Medicare Part D Notice of Creditable Coverage • Summary of Benefits and Coverage (SBC) • COBRA Administration • Adding or dropping Dependents during COBRA • Cost of COBRA Continuation Coverage • COBRA premium payments • Health Reimbursement Account (HRA) balances or other questions • Beneficiary designation for death and accidental death and dismemberment benefits	**Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds Administration, LLC (the "Fund Office")** **Phone** Phone hours for the Fund Office's Health and Welfare Service Department are 8am–5pm, Monday–Friday, excluding holidays. 714-220-2297 562-408-2715 877-284-2320 **Fax** Eligibility and Enrollment: 714-827-7564 Claims: 714-828-6573 **Walk-in / Mail** 8am–5pm, Monday–Friday, excluding holidays. 6425 Katella Avenue, Cypress, CA 90630-5238 or P.O. Box 6010, Cypress, CA 90630-0010 **Online** **scufcwfunds.com**
PPO Network for Medical Benefits; Utilization Management (UM) Company for Medical Benefits • Precertification of medical inpatient admissions and certain other medical services • Appeals of Utilization Management decisions, including requests for precertification • Online Medical Network Provider Directory *(Always check with the Provider at the time of service to be sure they are still in-network.)*	**Anthem Blue Cross of California PPO Network** **In California:** Anthem Blue Cross Prudent Buyer Network **www.anthem.com/ca** **Outside of California:** BlueCard Network **Medical Precertification:** 800-274-7767 **Find a PPO Provider in California:** 855-686-5613 **Find a PPO Provider outside California:** 800-810-2583 Obtain precertification for all inpatient admissions for medical or surgical care. If you use a PPO Hospital, your Hospital and Physician will automatically request the certification or authorization for you, and Anthem Blue Cross of California will issue you a letter with their approval or denial. If you use a Non-PPO provider, you ***must*** call 800-274-7767 for Precertification. **Caution:** Use of a **Non-PPO** Hospital, facility or provider could result in you having to pay a substantial balance of the provider's billing (known as Balance Billing).
Prescription Drug Program Administered by OptumRx • Provides prescription drug coverage for Participants covered under the Indemnity PPO plans, the Kaiser HMO and the Anthem HMO • ID cards for prescription drugs • Retail participating pharmacies • Prescription drug information • Formulary generic and brand name drugs • Precertification of certain drugs • Market Priced Drug (MPD) program (Preferred MPD drugs) • Request an exception to the MPD program	**OptumRx** • **www.optumrx.com** — Have your Optum Rx ID card handy — you'll need your Rx ID number from the card to use the site. Through the site, you can review drug costs and find lower-cost alternatives, calculate annual costs and savings and print information about MPD alternatives to discuss with your doctor. • 888-715-7573 — OptumRx call center representatives are available 24 hours a day, 7 days a week, to answer questions about the Prescription Drug program.

Quick Reference Chart *(continued)*	
Information Needed	**Whom to Contact**
Mental Health and Chemical Dependency Services, Employee Member Assistance Program (EMAP) for PPO and Anthem HMO Participants (not Kaiser Participants). • Mental Health and Chemical Dependency Services, in-network providers and referrals • Mental Health and Chemical Dependency Claims and Appeals • Precertification of Mental Health and Chemical Dependency Hospital Admissions, intensive outpatient services and/or partial day care • Utilization Management (UM) for Mental Health and Chemical Dependency **In addition to the above EMAP services, HMC is also responsible for:** • Disease Management Program • Questions regarding designated hospitals for hip and knee surgery • Health Risk Questionnaire (HRQ)	**HMC HealthWorks (HMC)** **Participants Call:** 800-461-9179 **Providers Call:** 855-487-8914 Send Behavioral Health/Chemical Dependency Claims to: HMC Health Works P.O. Box 981605, El Paso, TX 79998-1605 EDI Partner: Emdeon EDI Payer ID: 75318 **www.hmchealthworks.com** **Phone:** • Call HMC for the Disease Management program: 888-369-5052 • Call HMC for Knee/Hip information: 844-751-4530 You can access and return your HRQ in one of three ways: • **Phone:** Call HMC (the HRQ provider): 888-901-0477 • **Paper:** Contact HMC, the Fund Office or your Union Local to request a paper HRQ • **Online: www.takeyourHRQ.com**
Podiatry PPO Network (Exclusive Provider Network) • Podiatry Network for PPO Participants • Podiatry Network Provider Directory • Precertification of podiatry services (Precertification is required for ***all*** podiatry surgery or major services).	**Podiatry Plan, Inc. (formerly PPOC)** Call 800-367-7762 or 415-928-7762 for Precertification of podiatry surgery and/or a list of Podiatry Plan providers. In California, you must use providers in the Podiatry Plan network or there is no coverage.
Kaiser HMO Medical Plan (HMO Option for Platinum Plus Participants Only) • Medical appointments • Prescription drugs are provided through OptumRx (except that the MPD program does not apply) • Ancillary benefits provided by the Fund including chiropractic services, acupuncture/acupressure, vision and injectable drugs not covered by Kaiser • Medical claims and appeals (including mental health and substance abuse) • HMO benefit information	**Kaiser Permanente HMO** • 800-464-4000 • **www.kp.org**
Anthem™ Blue Cross HMO Medical Plan (HMO Option for Platinum Plus Participants Only) • Medical appointments • Prescription drugs are provided through OptumRx • Mental health and substance abuse services are provided through HMC • Ancillary benefits provided by the Fund include chiropractic services, acupuncture/acupressure, vision and injectable drugs not covered by Anthem • Medical claims and appeals • HMO benefit information	**Anthem™ Blue Cross HMO** • 800-627-5342 • **www.anthem.com/ca**
HIPAA Privacy Officer and HIPAA Security Officer • HIPAA Notice of Privacy Practice	**Privacy Officer** Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds Administration, LLC 6425 Katella Avenue, Cypress, California 90630 Phone: 714-220-2297 ext. 380 • Fax: 714-220-2002

Participating Union Locals			
UFCW Local 8 — Bakersfield	661-391-5773 or 661-391-5770	1910 Mineral Court Bakersfield, CA 93308	**ufcw8.org**
UFCW Local 135			**ufcw135.com**
San Diego (main office)	619-298-7772 or 800-545-0135	2001 Camino Del Rio South San Diego, CA 92108	
San Marcos	619-298-7772 or 800-545-0135	323-A South Rancho Santa Fe Road San Marcos, CA 92078	
UFCW Local 324			**ufcw324.org**
Buena Park	714-995-4601 or 800-244-8329	8530 Stanton Avenue Buena Park, CA 90620	
UFCW Local 770			**ufcw770.org**
Los Angeles (Main Office)	213-487-7070 or 800-832-9770	630 Shatto Place Los Angeles, CA 90005	
Arroyo Grande	805-481-5661	140 W. Branch Street Arroyo Grande, CA 93420	
Camarillo	805-383-3300	816 Camarillo Springs Road, Suite H Camarillo, CA 93012	
Harbor City	310-784-5340	25949 Belle Porte Avenue Harbor City, CA 90710	
Huntington Park	323-923-1510	5400 Pacific Boulevard Huntington Park, CA 90255	
Santa Barbara	805-681-0770	4213 State Street, Suite 201 Santa Barbara, CA 93110	
Santa Clarita	661-259-9900	27125 Sierra Highway, Suite 204 Santa Clarita, CA 91351	
UFCW Local 1167 — Bloomington	909-877-1110	855 West San Bernardino Avenue Bloomington, CA 92316	**ufcw1167.org**
UFCW Local 1428 — Claremont	909-626-6800	705 West Arrow Highway Claremont, CA 91711	**ufcw1428.org**
UFCW Local 1442 — Inglewood	310-322-8329	9075 S. La Cienega Boulevard Inglewood, CA 90301	**ufcw1442.org**

Eligibility — When Coverage Begins and Ends

Initial Eligibility

To earn your initial eligibility for coverage under the Plan, you must first meet the requirements for both the length of service and required hours (as shown in the chart to the right) for your job classification. Once you have enrolled and coverage begins, you must continue to work the required hours each month to earn continuous eligibility. In addition, you must pay the required contribution to premium.

Make sure you timely enroll for coverage.

Enrollment materials will be mailed to you well before your deadline to enroll. You should contact the Fund Office before your 7th month of employment (before your 19th month for Clerk's Helpers) if you have questions and to make sure you enroll by the deadline. If you fail to enroll when you first become eligible, you will have to wait until the next Open Enrollment period to do so (or for a Special Enrollment opportunity, if applicable). Open Enrollment generally begins in the fall, with enrollment changes effective on the following January 1.

Length of Service for Participants Other Than Clerk's Helpers

For Participants other than Clerk's Helpers, you generally become eligible for coverage on the first day of your seventh month of employment. After your first month of employment, you must work at least 20 hours in each of the next three months and the Required Hours in the fifth month.

Length of Service for Clerk's Helpers

Clerk's Helpers generally become eligible for coverage on the first day of the 19th month of employment. You must work the required hours in the 17th month for initial coverage in the 19th month.

For Clerk's Helpers, the Affordable Care Act (ACA) provides you the option to enroll for coverage earlier, by paying the full premium cost for coverage (you will pay 100% of the COBRA premium) as follows:

- If you average 30 or more hours per week during your first 11 months of employment, you may be eligible to enroll starting in your 14th month of employment; or
- You may be eligible to enroll before your 19th month, when you reach 1,200 hours of service.

Please contact the Fund Office if you are interested in enrolling before the 19th month.

Required Hours

In order to become eligible for coverage and to maintain health care coverage for yourself and your eligible Dependents, you must work the required hours each month as shown in the chart below:

Job Classification	Required Hours
Plan A Clerks, Meat Clerks, General Merchandise Clerks and Pharmacists	92
Plan A Meat Cutters and Uniform Department Employees	76
Plan A Clerk's Helpers	64

The hours you work in one week are credited to you as of each Sunday based on the standard industry workweek, which is Monday through Sunday. Your monthly hours are credited as of the last Sunday of each month.

The required hours used to earn eligibility are:

- Straight-time hours you have actually worked and for which you are paid; and
- Hours with which you are credited for paid holidays, paid sick leave, paid jury duty and paid vacation days.

Dependent Eligibility

If you elect coverage for yourself, you can also choose to enroll your eligible Dependents. Only individuals who qualify as your Dependents can be enrolled for coverage in the Plan.

Dependents eligible for the Fund's health care coverage are:

- Your lawful Spouse or Domestic Partner (Clerk's Helpers may not enroll a Spouse or Domestic Partner for coverage)
- Your child(ren) under age 26, if they are your:
  - Natural child;
  - Legally adopted child or child placed with you for adoption;
  - Stepchild; or
  - A child who is required to be covered under a QMCSO (Qualified Medical Child Support Order) or NMSN (National Medical Support Notice).
- Your eligible Domestic Partner's child(ren) who meet the following criteria:
  - They are unmarried;

- They are dependent on you for support and maintenance; and
- They are (1) under age 19, or (2) under age 24 and a full-time student at an accredited educational institution.

- A foster child, including:
  - A foster child under age 26, who is placed with you by a government agency or court order.
  - An unmarried foster child whose status is established by a Natural Parents' Certification and who satisfies the following: (i) is less than 19 years of age, or is a full-time student in an accredited educational institution, age 19 to age 24; (ii) is totally dependent upon you for support and maintenance; (iii) resides with you on a permanent basis; and (iv) either (a) one or both natural parents of the child, if living, have given you authority to exercise parental control and responsibility as though the child were your natural child, or (b) if one or both of the child's natural parents reside with you, the parent(s) must be under age 18, unmarried, and totally dependent upon you for support and maintenance.

- An "over-age" disabled child who is unmarried, is totally dependent on you for support (the child's other sources of income may not exceed $6,403 per calendar year, as adjusted annually, except from Social Security or other sources of public aid), is unemployable because of a permanent mental or physical disability, and satisfies one of the following:
  - *Your natural* child*, legally adopted* child *or stepchild*. Coverage may be provided to the child after age 25 if his or her disability began before age 26.
  - *Your Domestic Partner's* child. Coverage may be provided to the child after age 18 if his or her disability began: (1) before age 19, or (2) before age 24 while a full-time student at an accredited educational institution.
  - *A foster* child *placed by a government agency or court order*. Coverage may be provided to the child after age 25 if his or her disability began prior to age 26 or as required by applicable law.
  - *A foster* child *not placed by a government agency or court order who is dependent on you for support*. Coverage may be provided to the foster child after age 18 if his or her disability began: (1) before age 19, or (2) before age 24 while a full-time student at an accredited educational institution.

For children of a Domestic Partner and foster children not placed by a government agency or court order: If the Plan receives a written certification from a covered Child's treating Physician that:

1. The Child is suffering from a serious Illness or Injury; and
2. A leave of absence (or other change in enrollment) from a postsecondary institution is Medically Necessary, and the loss of postsecondary student status would result in a loss of health coverage under the Plan, then the Plan will extend the Child's coverage for up to one year. This maximum one-year extension of coverage begins on the first day of the Medically Necessary leave of absence (or other change in enrollment) and ends on the date that is the **earlier** of (1) one year later, or (2) the date on which coverage would otherwise terminate under the terms of the Plan.

Domestic Partners and/or Domestic Partner's children may not qualify as a tax dependent of the Employee and as such, the Employee may be required to pay tax on the value of the benefits provided to the Domestic Partner and/or the Domestic Partner's child(ren). This is called "imputed income" and the Employee will have to pay tax withholding on this amount.

When Your Dependents Become Eligible for Coverage

For Silver and Gold Clerks

If you are in the Silver or Gold Plan, you may enroll your eligible Children on the same date you are first eligible for coverage. You may enroll your Spouse/Domestic Partner as follows:

- Your Spouse/Domestic Partner becomes eligible for coverage on the first day of the calendar month after you complete 24 months of employment; or
- You have the option to enroll him or her earlier. You may do so effective on the first of the month that is 60 days after you work 1,200 hours. If you elect this early enrollment, you will pay the full cost for his or her coverage until you complete 24 months of employment.

For Platinum Plus or Platinum Clerks (Including Pharmacists)

If you are in the Platinum Plus or Platinum Plan, you may enroll your Spouse/Domestic Partner and eligible Children on the same date you are first eligible for coverage.

For Clerk's Helpers

If you are a Clerk's Helper, you cannot enroll your Spouse/Domestic Partner.

You may enroll your eligible Children on the same date you are first eligible for coverage. The option for earlier enrollment, as explained above under "Length of Service For Clerk's Helpers" also applies to your eligible Children. If you opt for earlier coverage, you will be required to pay up to the full cost of their coverage until you have completed 18 months of employment. For more information, contact the Fund Office.

Continuing Eligibility

Once your health care coverage begins, you must continue to work the required hours each month to continue your eligibility. You earn continuing eligibility on a "skip-month" basis — meaning, when you work the required hours in one month, you will be eligible for benefits during the second month after the month you worked the required hours. Here are a few examples:

- Working the Required Hours in April gives you eligibility in June.
- Working the Required Hours in May gives you eligibility in July.
- If you work the Required Hours in April but not enough hours in May, you will have June eligibility, but you will not have eligibility in July.

Your eligibility will terminate at the end of the month in which your employment ends or if you are laid off.

If your eligibility ends because your employment ended, you were laid off, or if you failed to work the required hours for eligibility, you may elect COBRA Continuation Coverage.

How to Reestablish Eligibility

Your options for reestablishing benefits eligibility depend on the manner in which you lose eligibility and the timing for your return to work.

If you are laid off or terminated, and return to Covered Employment in fewer than 120 consecutive days, you will reestablish eligibility on a skip-month basis once you work the Required Hours. For example, an Employee terminated in May who returns to Covered Employment and works the Required Hours in July will earn eligibility for benefits for the month of September.

If your employment terminates and you are rehired by your same Employer, or another Employer, before the end of the month in which your coverage ends, your coverage can continue without interruption. For example, if you terminate with Employer A on July 15th, and are hired by Employer B on July 18th, you will remain covered in July and August. And, provided you work sufficient hours in July between both Employer A and Employer B, you will also be covered in September.

If you are laid off or terminated and you return to Covered Employment after 120 consecutive days or more, you will have to reestablish initial eligibility in the Silver Plan. However, if you are laid off for more than 120 days but are recalled by your same Employer within 12 months, your eligibility will be reestablished on a skip-month basis.

Example: Jack enrolls for benefits during Open Enrollment, and his coverage takes effect on January 1. He does not work the Required Hours in February to maintain coverage in April. However, he works the required hours in March and will again have benefit coverage in May. He can make a COBRA payment to cover April if he wishes. (See page 73 for more information on COBRA payments.)

The following year, Jack's employment is terminated in June, but he is then rehired in August. Since he is rehired in fewer than 120 days, he can reestablish his eligibility on a skip-month basis as soon as he works the required hours. If he works enough hours in August (the month of his rehire), he will be eligible for benefits in October. If Jack is rehired more than 120 days after his termination, he will be required to satisfy the initial eligibility rules outlined on page 6.

However, if Jack is laid off and is recalled by his Employer to return to work within the 12-month recall window, he can reestablish eligibility on a skip-month basis as soon as he works the Required Hours. In this same recall scenario, if Jack was laid off before he established initial eligibility, the number of months worked prior to his layoff will count towards his initial eligibility waiting period.

Enrollment

Generally, you are allowed to enroll for coverage when you first become eligible for coverage or during a later Open Enrollment period. Under certain circumstances, you may be able to enroll mid-year, if you or one of your Dependents has a qualified life event entitling you to a Special Enrollment Right (such as a loss of other coverage or the birth of a new Child).

Before you first become eligible for the Fund's health care coverage, you will receive an enrollment packet from the Fund Office. Complete the enrollment form and return it to the Fund Office by the deadline noted in your enrollment materials. If you have not received the enrollment packet a month before your initial eligibility date, contact the Fund Office.

To enroll a Dependent, you must provide the Fund with copies of certain documents, which are listed in the instructions provided with your enrollment form. You must immediately notify the Fund if you get a divorce or your Domestic Partnership ends.

Once enrolled and eligible for coverage, your premium contribution will be deducted from your paycheck. Deductions taken in the current month pay for coverage in that month.

You generally cannot drop coverage for yourself or any enrolled Dependents until an Open Enrollment period. Exceptions are provided in very limited circumstances (such as if you are paying the full cost for a Dependent's coverage, if you divorce, if your Child reaches the limiting age, or if you or a Dependent becomes eligible for Medicaid). Outside of Open Enrollment, you can change your plan choices for any reason once in a five-year period or if you have a Special Enrollment event. Contact the Fund Office if you have questions.

If you choose not to enroll when you first become eligible (by not responding by the deadline shown in your enrollment materials) you will not have Fund health care coverage. Also, you will not be permitted to enroll until the next Open Enrollment period (with coverage effective on January 1 of the following year). For example, if you chose not to enroll when you became eligible on May 1, 2019, you will have to wait until the next Open Enrollment period, in late fall 2019, to enroll, and your coverage would not be effective until January 1, 2020. However, certain qualified life events may provide you with a special enrollment right and allow you to enroll at other times during the year.

Contribution to Premium and Payroll Deductions

Participants are required to pay a share of the cost for coverage through weekly payroll deductions. The standard weekly contribution to premium amounts depends on which eligible family members you enroll. In most instances, weekly amounts are as follows:

- **For Employee-only coverage:** $7.00 per week
- **For Employee plus eligible Child(ren):** $10.50 per week
- **For Family coverage (Employee plus eligible Spouse/ Domestic Partner, with or without eligible Children):** $15.00 per week

Clerk's Helpers who enroll early must pay the full cost of coverage, in the amount of 100% of the COBRA premium rate.

Your employer automatically deducts your contribution to premium from your paycheck on a weekly basis. You must sign an enrollment form to permit your employer to withhold your premium contribution from your paycheck.

Your contribution to premium is generally owed for the month in which you are provided coverage. Thus, payroll deductions taken in May generally pay for May coverage.

If you fall behind in your contributions, the Fund will temporarily increase your deductions to recover the amount you owe. If your employer is unable to withhold your contributions for an extended period, you may have to make a direct payment to the Fund Office to continue your coverage. Contact the Fund Office if you have any questions.

Requirement for Working Spouses/ Domestic Partners (Working Spouse Rule)

Throughout this Section use of the term "Spouse" refers to your covered Spouse or Domestic Partner).

The Fund's health care Plans coordinate with other employers' health care plans to ensure that those other plans share in the cost of benefits for working families. If your Spouse is eligible for other health care coverage through his or her own employment, this Fund requires that your Spouse enroll in the best health care benefits (medical, dental, orthodontic, vision, hearing, etc.) available through his or her own employment, for employee-only coverage. Your Spouse must enroll in the best coverage available through his or her employer, even if that other health coverage requires payment of a premium by your Spouse.

When enrolling your Spouse, you will be required to certify, under penalty of perjury, whether your Spouse has access to other group health coverage through his or her employer. If coverage is not available through your Spouse's employer, a signed certification on the other plan's (or the employer's) letterhead must be provided to the Fund Office.

If your Spouse is not working now but becomes eligible for coverage through employment in the future, he or she must, at the time coverage becomes available, enroll in the best health care plan(s) available for employee-only coverage. In addition, anytime there is a change in your Spouse's health care coverage, you must notify the Fund Office immediately. Failure to do so will result in reduced benefits as described on the next page.

The Fund may, at anytime, require your Spouse to verify whether he or she has access to health coverage through his or her employer.

This rule does not apply to coverage for Dependent Children. Only your Spouse is required to enroll in the best employee-only health care coverage that is available from his or her employer.

Consider whether enrolling your Spouse in the Fund makes sense for your family. It may not be economical for you to pay to cover your Spouse under this Fund if he or she already has coverage through his or her own employment (which is primary coverage for him/her). This is because the Fund's Plan will be secondary to your Spouse's employer-provided plan, and the Fund will coordinate with that plan on a Non-Duplication of Benefits basis. So, the Fund will pay benefits only if the other plan's payment is less than the amount the Fund's Plan would have paid had the Fund's Plan been the only plan providing benefits.

Consequences of the Working Spouse Rule

If your Spouse does not enroll in the best coverage available through his/her employer, or if you or your Spouse fail to accurately and timely respond to a Working Spouse inquiry:

1. Your Spouse's benefits under this Plan will be reduced by 60%;
2. You and your Spouse will be responsible for the portion of the bill not paid by the Fund; and
3. You and your Spouse will be responsible for reimbursing the Plan any amounts paid by the Plan on behalf of your Spouse that should not have been paid.

Prior Coverage with UFCW Reciprocal Plans

If you were eligible for benefits under a Reciprocal UFCW Fund immediately before beginning Covered Employment under this Fund, you may not have to complete the initial eligibility requirements, provided you worked Required Hours under the Reciprocal UFCW Fund in the calendar month prior to the month in which you began working in Covered Employment.

In order to obtain eligibility under this provision, you must contact the Fund Office within 60 days of beginning Covered Employment under this Fund.

Example: If you begin working for a Contributing Employer in February and you worked Required Hours under a reciprocal UFCW Fund in January, coverage under this Fund will begin on March 1st.

The following UFCW Benefit Funds have reciprocity with this Fund:

- Southern California Drug Benefit Fund
- UFCW & Employers Benefit Trust, Northern California

Return to Covered Employment (120 Day Rule)

For purposes of: (1) gaining initial eligibility on a skip month basis, without having to satisfy initial eligibility requirements; and/or (2) determining plan-level benefits under this Fund (that is for the purpose of determining whether you will be in the Silver, Gold, Platinum or Platinum Plus Plan), the Fund will use your previous hire date if you return to Covered Employment with the same Employer or a different Employer within 120 days from when your Covered Employment last terminated.

The Fund will use a new hire date, and you will have to satisfy the initial eligibility requirements to earn initial eligibility under the Silver Plan, if you do not return to Covered Employment within 120 days.

If Your Employer Transfers You to Covered Employment

If you transfer from a non-union position or from outside the area to Covered Employment with the same Employer without an intervening quit, discharge or retirement, you may be eligible for immediate eligibility and/or to use your prior employment in determining your plan-level benefits.

To find out whether you may be entitled to immediate eligibility or use of your prior employment in determining plan-level benefits, please contact the Fund Office within 60 days of beginning work in Covered Employment.

Special eligibility rules may also be available if you are employed by an Employer first coming under a Collective Bargaining Agreement with the Union. Contact the Fund Office for more information.

Proof of Dependent Status

The Plan requires specific documentation to verify your Dependents' status. Such documentation may include a birth certificate, marriage certificate, proof of the Dependent's age, and the Dependent's Social Security Number.

Below are other items the Fund may request upon enrollment and periodically thereafter to prove Dependent status. **Note that failure to provide timely proof of Dependent status means that your Dependent will not have coverage and will be unable to enroll in the Plan until the next Open Enrollment period (or subsequent Special Enrollment event).**

- **Spouse:** Certified county marriage certificate or official marriage certificate issued from the applicable governing body in the jurisdiction that the marriage was entered into.
- **Natural Children:** Certified county birth certificate. In the event you have a newborn baby, be sure to request enrollment with the Fund Office as soon as possible after the baby's birth, and in any event within 120 days. This will ensure the baby's coverage is in effect retroactive to his or her birth date. Then, you must provide a copy of the certified county birth certificate to the Fund Office within six months after the child's birth date. If the county birth certificate is not received within six months, the child's coverage will be terminated.
- **Stepchild:** County-issued certified birth certificate with the natural parents named and Participant's certified marriage certificate.
- **Adopted Child or Child Placed for Adoption:** Adoption decree or court order signed by the judge showing that Employee has adopted the child. For a child placed for adoption, a copy of the Petition to Adopt, court order placing the child with the Participant (if applicable), and the Fund's *Application for Coverage Pending Adoption Placement* form.
- **Domestic Partner:** A certified copy of the Certificate of Registration of Domestic Partnership filed with the California Secretary of State. Both partners must satisfy the criteria for Domestic Partnership under California law, and you may enroll your opposite-sex Domestic Partner only if at least one of you is age 62 or older.
- **Children of a Domestic Partner:** For children of your Domestic Partner, the county-issued certified birth certificate. For adopted children of your Domestic Partner, the court order signed by the judge showing that your Domestic Partner has adopted or intends to adopt the child. For children of your Domestic Partner who are age 19 through age 24, annual certification of full-time student status and any additional required proof that the child(ren) is attending an accredited school or college as a full-time student as defined by the institution, as well as proof that he or she qualifies as your tax Dependent under IRC §152, if applicable.
- **Disabled Dependent Child:** A completed Eligibility for Disabled Dependent Children form (go to **scufcwfunds.com/eligibility-enrollment/forms-documents** or call the Fund Office to obtain the form), as well as proof of the child's status as your Child and documentation proving the child's eligibility for coverage as an "over-age" disabled Dependent, including evidence of the child's incapacity. (Annually, the Participant must also provide proof that the child continues to satisfy the Plan's requirements for eligibility as an over-age disabled Dependent Child).
- **Qualified Medical Child Support Order (QMCSO):** Valid QMCSO document signed by a judge or a National Medical Support Notice.
- **Foster Children:** A completed *Application for Coverage of a Foster Child as an Eligible Dependent* form and any supporting documentation. Call the Fund Office or download the application form from the Fund's website at **scufcwfunds.com/eligibility-enrollment/forms-documents**.

Open Enrollment — Your Opportunity to Make Changes

Open Enrollment is the once-a-year period of time designated by the Board of Trustees during which eligible Employees may make certain benefit election changes. Specifically, during Open Enrollment you may enroll yourself and/or any eligible Dependents, you may drop coverage for yourself and/or any Dependents, you can change your dental plan and you can change your medical plan if you are in the Platinum Plus Plan. Open Enrollment is held annually. It generally begins in the fall, with coverage changes effective the following January 1st.

Information regarding Open Enrollment will be sent to you at the beginning of the Open Enrollment period.

Information You Need Before Completing Your Enrollment Forms

You will need the following information to enroll or make changes to your enrollment:

- **Social Security numbers** for you and all of your Dependent(s) you want to enroll in the Plan.
- **Dates of birth** for all of your Dependent(s) you want to enroll in the Plan.
- **Other Insurance Coverage.** You will be asked to provide information on other health coverage or insurance. You will need to have:
  - Information on other health coverage that your Spouse/Domestic Partner is eligible for due to the Spouse's/Domestic Partner's own employment (even if your Spouse/Domestic Partner is not enrolled in the other plan). Information needed includes the employer's name, plan's name, policy number and contact information for the other employer and/or insurance plan.
  - Information on any other health coverage or insurance that covers you or any of your enrolled Dependents.

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 Plan Administrator, or its designee, the Social Security Number (SSN) of your Dependents for whom you have elected, or are electing, Plan coverage, and information on 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 Plan coverage but may also be requested at a later date.

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

Please refer to the chapter titled "Coordination of Benefits" for information on how your Plan coverage may be impacted by other insurance coverage.

Special Enrollment

Outside of Open Enrollment, you can change your plan choices for any reason once in a five-year period. You can also make certain changes if you or a Dependent has a special enrollment right due to a qualified life event.

Be sure to contact the Fund Office if you have questions about changing your coverage outside of Open Enrollment.

Qualified Life Events and Special Enrollment Rights

You, your Spouse/Domestic Partner, and/or your Children may be able to enroll in the Fund's medical coverage (or change your previous elections) outside of Open Enrollment under the following circumstances:

- **Acquisition of New Dependent.** You acquire a new Dependent (for example as a result of a marriage, registration of Domestic Partnership, birth, adoption, placement for adoption, or placement of a foster child).
- **Eligibility for Premium Assistance.** You or any of your Dependents become eligible for premium assistance through Medicaid or a state's children's health insurance program (CHIP).

- **Loss of Other Coverage.** You, your Spouse/Domestic Partner, and/or your Dependent Child(ren) lose medical coverage from another group health plan or health insurance policy. This includes a loss of coverage resulting from one of the following:
  - Loss of eligibility for the other coverage resulting from 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 (but not loss due to failure of an employee to pay premiums on a timely basis or termination of the other coverage for cause); or
  - 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; or
  - Termination of employer contributions toward that other coverage (if an employer just reduces contributions, this does not trigger a special enrollment right); or
  - 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; or
  - The other plan ceases to offer coverage to a group of similarly situated individuals that includes you and/or your Dependent; or
  - The other health insurance was provided under COBRA Continuation Coverage, and such COBRA coverage was "exhausted." COBRA Continuation Coverage is "exhausted" if it ceases for any reason other than (1) the failure of the individual to pay the applicable COBRA premium on a timely basis, (2) for cause (such as making a fraudulent claim or an intentional misrepresentation of material fact in connection with that COBRA Continuation Coverage), or (3) the termination of an employer contribution toward COBRA coverage.

Please note: Voluntarily dropping other coverage will not trigger special enrollment rights.

Deadlines for Requesting Special Enrollment

If you request a special enrollment within 120 calendar days of one of these events, coverage will be retroactive to the date the event occurred.

However, HMO Participants should note that the HMOs may limit the period for retroactive enrollment and coverage. If unavailable through the HMO, your retroactive coverage will be provided through the Indemnity PPO Medical Plan.

If you request a special enrollment more than 120 days following the event, but no later than the end of the next Open Enrollment period, your new coverage will begin on the first day of the month after the Fund Office receives your enrollment form.

Individuals Eligible to Enroll Upon Special Enrollment

The individual(s) seeking special enrollment must otherwise be eligible for the Fund's medical coverage in order to enroll.

- **Loss of Other Coverage:** If you are the individual who lost other medical coverage, then you and any of your Dependents may enroll. If, on the other hand, your Dependent is the individual who lost other coverage, then only you and that Dependent may enroll.
- **Acquisition of New Dependent:** You, your Spouse/Domestic Partner, and any newly acquired Dependent(s) may enroll.
- **Eligibility for Premium Assistance:** The individual who became eligible for premium assistance may enroll.

Coverage Available Upon Special Enrollment

Individuals enrolled during Special Enrollment have the same opportunity to select plan benefit options (when such options exist) at the same costs and the same enrollment requirements, as are available to similarly-situated Employees at Initial Enrollment. The Employee and all Dependents must be enrolled in the same Plan option.

Qualified Medical Child Support Orders (QMCSO)

The Fund will provide benefits in accordance with a Qualified Medical Child Support Order (QMCSO) or a National Medical Support Notice. According to 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 that the Plan recognize the child as a Dependent, even though the child may not meet the Plan'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;
- 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.

1. An order is not a QMCSO if it requires the Plan to provide any type or form of benefit or any benefit option that the Plan 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.
2. If a court or state administrative agency has issued an order with respect to health care coverage for any Dependent 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 Plan, and advise them of the procedures to be followed to provide coverage of the Dependent Child.
3. **Enrollment Related to a Valid QMCSO:** If the Plan has determined that an order is a valid QMCSO, it will enroll the Dependent Child as of the earliest possible date following the date the Plan determined the order was valid, without regard to typical enrollment restrictions. The QMCSO may require the Plan to provide coverage for the Employee's Child(ren) and to accept contributions for that coverage from a parent who is not a Plan Participant. The Plan will accept a request for enrollment of the Child specified by the QMCSO from either the Employee or the custodial parent. Coverage of the Child will become effective as of the date specified on the QMCSO, or if not specified, the first day of the month after the order is determined to be valid by the Plan. Coverage will be subject to all terms and provisions of the Plan, including any requirements for authorization of services, as permitted by applicable law.
4. **Contributions for Coverage:** No coverage will be provided for any Child under a QMCSO unless the applicable contributions for that Child's coverage are paid, and all of the Plan's requirements for enrollment and coverage of that Child have been satisfied. Contributions required for coverage under a QMCSO are the total Employee contributions required for coverage of the Employee plus eligible Children.
5. **Termination of Coverage:** Generally, coverage under the Plan terminates for a Child when the period of coverage required under the QMCSO ends or for the same reasons coverage terminates under the Plan for other Children. This includes termination of coverage for failure to pay any required contributions. When coverage terminates, the Child may be eligible for COBRA Continuation Coverage. See also the COBRA section of this document.
6. **Additional Information:** For additional information (free of charge) regarding the procedures for administration of QMCSOs, contact the Fund Office.

Moving Outside the HMO Plan's Service Area

If you are enrolled for coverage in one of the HMO Plan options **and** you move your residence to a place outside the HMO's service area you will be permitted to enroll in the Indemnity PPO Plan. Alternatively, you may be eligible to enroll in the Plan's other HMO option. You should submit a completed enrollment form as soon as possible after moving out of the service area.

When Coverage Ends

Your coverage ends on the earliest of the last day of the month in which:

- Your employment ends;
- You fail to work the required hours to continue your eligibility. In this case, your coverage will end on the last day of the month in which you were last eligible for coverage;
- You are laid off;
- You enter the Armed Forces (the military) on full-time active duty;
- The Plan is discontinued;
- You die;
- You fail to pay contributions to premium required for your coverage. In this case, you may be provided up to a three-month grace period before your coverage will be terminated. (However, a grace period will not be applied if you qualify for a Disability Extension);
- Your employer fails to make timely contributions on your behalf. In this case, your coverage will generally be terminated three months after your Employer fails to contribute to the Plan. You will be given advance notice of the termination; or
- You are no longer eligible to participate in the Plan.

Dependent coverage ends on the earliest of the last day of the month in which:

- The Employee's coverage ends. In the case of the Employee's death, coverage for enrolled Dependents will extend to the end of the month in which the Employee died;
- Your covered Spouse or Domestic Partner no longer meets the definition of Spouse or Domestic Partner because, for example, you divorce or your marriage/Domestic Partnership is annulled or dissolved;
- Your child, including a stepchild, no longer meets the definition of a Dependent because, for example, the child reaches the limiting age and is no longer eligible for coverage or you divorce and your stepchild is no longer your stepchild;
- For Dependents under a QMCSO, the expiration of the period of coverage stated in the QMCSO, if applicable;
- The date your Spouse or Domestic Partner enters the Armed Forces on full-time active duty;
- The date Dependent coverage is discontinued under the Plan; or
- The date of your Dependent's death.

When coverage under this Plan terminates you may have the option to buy temporary continuation of this group health plan coverage by electing COBRA Continuation Coverage, or if you are covered under an HMO, to convert your coverage to an individual insurance policy (called an individual conversion policy). You may also look into your options to buy individual health insurance coverage from the Health Insurance Marketplace.

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

You (or your Spouse/Domestic Partner or any of your Children) should notify the Fund **immediately** if any of your Dependents lose Dependent status or otherwise become ineligible for health care coverage from the Fund. You ***must*** **notify the Plan as soon as possible but *no later than 60 days*** after the date:

- **You get divorced** — Provide the Fund with the date of the dissolution of marriage and a copy of the Dissolution of Marriage.[1]
- **Your Domestic Partnership terminates** — Provide the Fund with the date of the termination and provide a copy of the Decree of Dissolution of Domestic Partnership or a completed Notice of Termination of Domestic Partnership.
- **Your child is no longer an eligible Dependent because of age, loss of status as your foster child or stepchild, loss of student status (applicable to Domestic Partner's children and foster children established by Natural Parent's Certification), or no longer qualifies for coverage as a disabled child above age 26** — 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.

If you fail to notify the Fund of your Dependent's loss of eligibility 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 he or she no longer qualified as your Dependent.

Also, failure to timely notify the Fund may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage.

If you timely notify the Fund of one of the above events, your Dependent will have the opportunity to elect COBRA continuation coverage. Please see page 70 for more information.

You may notify the Fund of any of these events by sending a letter to the Fund Office or by filling out the Deleting Dependents section of an Enrollment Form and sending the form to your Union Local or to the Fund Office. You may also call the Fund Office and they will send you a form to complete.

[1] *The Fund will temporarily suspend benefits as soon as a divorce or dissolution of a Domestic Partnership is reported. Eligibility for benefits will end when the divorce or dissolution is final.*

Rescission of Coverage

In accordance with the requirements in the ACA, the Plan will not retroactively cancel or terminate coverage (a rescission) except in the circumstances permitted by law, such as when contributions and self-payments are not timely paid, or, 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 coverage (retroactively cancel coverage): enrolling someone as a Dependent who does not qualify as a Dependent or knowingly submitting a false claim or appeal for benefits.

Leave for Military Service/Uniformed Services Employment and Reemployment Rights Act (USERRA)

A Participant who enters military service will be provided continuation and reinstatement rights in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA), as amended from time to time. See section beginning on page 77 for a complete description of your rights under USERRA.

Disability Extension of Coverage (for Platinum and Platinum Plus Participants Only)

Disability extensions allow coverage to continue for a limited period of time when you are unable to work because of a non-work-related disability or a Workers' Compensation disability. If you are in the Platinum or Platinum Plus Plans and you qualify for a disability extension, coverage for you and your Dependents (who are covered on the date you became disabled unless you have a special enrollment event after that date) may be extended, as described in more detail to the right. Both non-occupational and occupational disabilities are covered. You must be receiving approved disability benefit payments as determined by the Trustees (including workers' compensation benefits), during the period(s) for which you are requesting hours credit for Disability Extended Coverage.

Duration of Extended Benefits for Platinum Plus and Platinum Participants

The length of the disability extension that you can receive is different depending on whether the disability is due to work (occupational disability):

- **Non-occupational Disability:** If Covered Employment is interrupted because of a non-job-related Illness or Injury that is recognized as a disability under the California Unemployment Insurance Code, you will receive six equivalent hours of work credit for each day of disability, for up to six consecutive months, provided that (1) you worked the Required Hours for the each of the two months immediately before the start of your disability leave, and (2) you received disability benefits under the California Unemployment Insurance Code (i.e., you received California State Disability benefits) for the period(s) for which you claim hours credit due to Disability.

  You must submit proof of receipt of State Disability benefits to the Fund Office in order to receive credit under this provision.

- **Workers' Compensation Disability (Occupational Disability):** If Covered Employment is interrupted because of a job-related Illness or Injury that is recognized as a disability under the Workers' Compensation laws of the State of California, and for which you receive Workers' Compensation disability benefits, you will receive six equivalent hours of work credit for each day of disability for up to 12 consecutive months.

  You must submit proof of receipt of Workers' Compensation disability benefits to the Fund Office in order to receive hours of work credit.

It is your responsibility to send copies of your State Disability or Workers' Compensation check stubs to the Fund Office to establish your entitlement to a disability extension. In addition, you are required to pay your applicable contribution to premium for any period(s) for which disability credits are used to extend coverage.

Once you have exhausted a Disability extension of coverage (either a 6-month extension for a non-occupational disability or a 12-month extension for Worker's Compensation Disability) you must return to Covered Employment and work Required Hours in each of two consecutive months before you are again eligible for a Disability extension of coverage.

Silver and Gold Participants are not able to extend their eligibility but may elect COBRA to continue their coverage during a disability leave. Silver and Gold Participants should submit proof of receipt of State Disability or Worker's Compensation benefits to the Fund Office.

California Paid Family Leave does not qualify for Extended Eligibility.

You must apply for a Disability Extension of coverage. You may obtain the application form from your Union Local or the Fund Office. You should return your completed application to the Fund Office within **60 days from the date your coverage ended or you received the COBRA Election notice**.

Family Medical Leave Act

If you work for an employer subject to the Family Medical Leave Act (FMLA), you may be entitled to unpaid leave for specified family or medical purposes, such as the birth or adoption of a Child, to provide care for a Spouse, Child or parent who is seriously ill, or for your own Illness. In general, employers subject to FMLA are those who employ 50 or more Employees. To find out more about family or medical leave and the terms on which you may be entitled to it, please contact your Employer.

This Fund provides extended coverage during periods of FMLA leave validated by your Employer. If you go on an FMLA leave of absence, please contact the Fund Office. Also, if you are taking FMLA for your own Illness, any Disability Extensions you have available will run concurrently with your coverage due to FMLA leave.

Continuation of Coverage

See the COBRA chapter beginning on page 70 for information on continuing your health care coverage.

Recovery of Overpayments

Whenever a benefit payment (including premiums for HMO coverage) exceeds the amount that should have been paid (an "overpayment"), the Fund shall have the right to recover the overpayment (plus interest at the same annual rate imposed for delinquent Employer contributions) from any person or organization to, or for, whom said payments were made or from any person whose acts, omissions, or representations caused overpayments. In the event that the Fund brings legal action to recover any such overpayment, the Fund shall 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 are 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 and/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 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 will be considered overpayments, and you will be required to reimburse the Fund for those benefits, including premiums the Fund paid for HMO coverage. See page 15 regarding the requirement to notify the Fund if your Dependent becomes Ineligible for Coverage.

Levels of Coverage

Plan A has four "levels" or "plans" of coverage: the Silver Plan, the Gold Plan, the Platinum Plan and the Platinum Plus Plan. Eligibility for each level is based upon when you were hired and/or the number of months you have been employed in Covered Employment without a break in service of 120 days or more.

Step-Up Benefit Upgrades (Silver, Gold and Platinum Benefits)

Plan Participants other than Clerk's Helpers can earn upgrades to their benefit level after reaching employment service milestones. They can "step-up" from their initial Silver benefits package to Gold after 3½ years of employment and "graduate" to the Platinum benefits level after 5½ or 6½ years of employment, depending on their date of hire as shown below. There is no step-up to Platinum Plus benefits.

Clerk's Helpers remain enrolled in the Silver Plan and can only graduate to the Gold Plan if promoted to a Clerk position.

Plan A Participants		
Benefit Level	**Hire Date**	**Months of Employment**
Silver	On or after March 1, 2004	6-42
Gold	Between March 1, 2004 and July 21, 2007	43-66
	On or after July 22, 2007	43-78
Platinum	Between March 1, 2004 and July 21, 2007	67+
	On or after July 22 2007	79+
Platinum Pharmacists	On or after October 6, 2011	N/A
Platinum Plus	• Clerks or Clerk's Helpers hired prior to March 1, 2004 • Pharmacists whose coverage transferred from the Southern California Drug Benefit Fund on January 1, 2015 • Pharmacists hired prior to September 19, 2011 by Albertsons, Ralphs or Vons • Pharmacists hired prior to July 1, 2014 by Stater Bros.	N/A

Silver Benefits for Participants Other Than Clerk's Helpers

Coverage for you and any enrolled Dependent Child(ren) begins as described on page 7.

For Participants other than Clerk's Helpers, your Spouse/Domestic Partner is eligible for coverage after you have completed 24 months of Covered Employment. However, you have **the option to enroll your Spouse/Domestic Partner earlier if you pay the full cost of coverage, as determined by the Board of Trustees. This early coverage is effective on the first of the month that is 60 days after you have completed 1,200 hours of Covered Employment.**

If you choose this "early" coverage for your Spouse/Domestic Partner, the Fund Office will send you coupons for payment of the full monthly premium amount for your Spouse/Domestic Partner coverage, and payment must be received by the Fund Office within the month due or coverage for your Spouse/Domestic Partner will be terminated. The premium for this Spouse/Domestic Partner coverage cannot be deducted from your paycheck. As an alternative, you may have the option of enrolling your Spouse/Domestic Partner for coverage under a Health Care Exchange/Marketplace.

After you have worked 24 months, the cost of covering your Spouse/Domestic Partner drops to the applicable weekly contribution provided under your Collective Bargaining Agreement, and will be deducted through payroll deductions. You will be mailed a letter and enrollment form informing you that your Spouse is becoming eligible for subsidized coverage and offering you the opportunity to enroll your Spouse/Domestic Partner when that happens.

Clerk's Helpers

Clerk's Helpers ***cannot*** enroll a Spouse/Domestic Partner for coverage.

Graduation to Gold Benefits

Eligible Participants (except Clerk's Helpers) step up from the Silver level to the Gold level of benefits the month after completing 3½ years of Covered Employment. Enhancements to benefits include lower Prescription Drug copays and higher maximums for dental, vision and orthodontic benefits as shown on your Silver/Gold Benefits Chart.

Graduation to Platinum Benefits

Eligible Participants (except Clerk's Helpers) graduate from the Gold level to the Platinum level of benefits upon completing the following service requirements:

- Plan A Participants hired after March 1, 2004 and before July 22, 2007, graduate to Platinum the month after completing 5½ years of Covered Employment.
- Plan A Participants hired on or after July 22, 2007, graduate to Platinum the month after completing 6½ years of Covered Employment.

In addition to other benefit upgrades, Platinum Plan benefit enhancements include larger contributions to your Health Reimbursement Account and lower annual Medical Out-of-Pocket Maximum limits in the Indemnity PPO Medical Plan (for services from PPO Providers). You will receive more information about Platinum benefits when you approach graduation.

Your weekly payroll deduction will not change because of a step up to Gold benefits or graduation to Platinum benefits.

Your Medical Plan Options

Participants in the Platinum Plus Plan may choose between the Indemnity PPO Medical Plan or an HMO (Kaiser Permanente HMO or Anthem™ Blue Cross HMO). Participants in the Silver, Gold and Platinum plans may only enroll in the Indemnity PPO Medical Plan.

Outside of Open Enrollment, you can change your plan choices for any reason once in a five-year period.

My Health/My Choices Program

THIS CHAPTER APPLIES ONLY TO EMPLOYEES AND THEIR SPOUSES OR DOMESTIC PARTNERS WHO ARE ELIGIBLE FOR AND ENROLLED IN THE INDEMNITY PPO MEDICAL PLAN.

PARTICIPANTS WHO ARE COVERED UNDER ONE OF THE FUND'S HMO PLANS ARE NOT ELIGIBLE FOR HRA FUNDS.

When you complete Healthy Activities (listed below), you earn funds for your Health Reimbursement Account (HRA). The higher your HRA balance, the less you pay of your own money for medical deductibles, Prescription Drugs and other covered expenses.

The way it works is simple. Each Calendar Year, you are responsible for paying:

- **An Annual Deductible:** The Deductible applies to most non-preventive medical services (like a visit to your doctor's office because you have the flu or a Hospital stay).
- **Coinsurance:** Once you meet the Deductible, you and the Plan share costs through Coinsurance.
- **Copays:** You also pay set costs called copays for most Prescription Drugs.

Each year, the Fund makes a base contribution to your HRA. The amount of your base contribution depends on your coverage category (i.e., Employee only; Employee + Children; or Family) and your Plan. You and your enrolled Spouse/Domestic Partner can increase your HRA balance by participating in certain healthy activities, as described in more detail on the next page.

When you go to the doctor or Hospital, the money in your HRA is automatically applied to your share (annual Deductible and Coinsurance) of your claims. The Fund will also reimburse your Prescription Drug copays from your available HRA balance — **if you have submitted a HRA Rx-HRA Option Form to the Fund Office** (available at **scufcwfunds.com** or call the Fund Office to have a form sent to you). *Note: The Fund will not use your HRA balance to pay for expenses that are not Covered Expenses.*

If you don't use all of your HRA in one year, the unused balance rolls over to the following year, so you can use it for future covered medical expenses — as long as you remain enrolled in the Indemnity PPO Medical Plan. If you have a balance in your HRA and you switch to an HMO plan option, you forfeit the remaining balance in your HRA.

The Fund will send you quarterly HRA statements showing base and earned HRA Contributions, Prescription Drug copay reimbursements, payments made for medical claims, and your account balance at the end of each calendar quarter.

Amount of HRA Funding

Calendar Year HRA Funding						
	Silver and Gold Plans			Platinum and Platinum Plus Plans		
Coverage Category	Employee Only	Employee + Child(ren)	Family*	Employee Only	Employee + Child(ren)	Family*
Automatic Base HRA Contribution	$125	$475	$250	$175	$500	$275
Maximum Added Earned Contribution	$425	$625	$850	$575	$750	$975
Total HRA Funding Opportunity (Base + Earned)	$550	$1,100	$1,100	$750	$1,250	$1,250
Number of Healthy Activities to earn the maximum HRA funding in one year	4	5	7	4	5	7

** Employee and Spouse/Domestic Partner with or without Children.*

The My Health/My Choices Incentive Program enables you to increase your HRA balance by doing Healthy Activities. When you complete a Healthy Activity, your HRA gets an "Earned HRA Contribution." Earned HRA Contributions are in addition to your "Base HRA Contribution," which is the amount provided automatically to your HRA each year.

Earned HRA Contributions are not automatic. You and your enrolled Spouse/Domestic Partner (if applicable) are allowed to complete a certain number of activities within one year in order to receive the maximum annual contribution to your Health Reimbursement Account. Children are not eligible to complete activities for HRA funding. For more information about this program, refer to the Fund's *My Health/My Choices Incentive Program Planner*. You may download a copy from **scufcwfunds.com/wellness/incentives** or request a copy from your Union Local or the Fund Office.

Healthy Activities

You (and your covered Spouse or Domestic Partner) can do any of the Healthy Activities shown in the chart that follows to earn HRA dollars up to the "maximum Added Earned Contribution" outlined in the chart on the previous page.

Your health plan is committed to helping you achieve your best health. Rewards for participating in a wellness program are available to all Employees in the Indemnity PPO Medical Plan. If you think you might be unable to meet a standard for a reward under this wellness program, you might qualify for an opportunity to earn the same reward by different means. Contact the Fund Office and we will work with you (and, if you wish, with your doctor) to find an alternative standard with the same reward that is right for you in light of your health status.

The Fund adds the HRA dollars that you have earned to your account during each year's "funding period". The HRA funding period runs from June 1 through May 31. Funds become available depending on when you complete healthy activities. Your HRA will receive funding for Healthy Activities processed between June 1 and December 31, during the first week of January. The Fund will add contributions for activities completed between January and May 31 as they are processed. After the Fund credits a Healthy Activity to your HRA, your additional funds become available to pay your eligible expenses. Only the balance on hand is available to pay your share of claims as they come in. HRA funds cannot be used to pay for previously processed claims.

Update contact information for you and your primary doctor OR create a portal account on the Fund's website.	**Gold & Silver:** $125 **Platinum & Platinum Plus:** $150	Provide the following information to the Fund Office: • Your home mailing address • Your phone number (home/mobile) • Your email address (if you have one) • Doctor's name • Office mailing address • Office phone number Return the Contact Information Form (available online at **scufcwfunds.com** or from the Fund Office).
Complete your Health Risk Questionnaire (HRQ)	**Gold & Silver:** $125 **Platinum & Platinum Plus:** $150	You can access and return your HRQ in one of three ways: • **Online: www.takeyourHRQ.com** • **Phone:** Call HMC (the HRQ provider) toll-free at (888) 901-0477 • **Paper:** Contact HMC, the Fund Office, or your Union Local to request a paper HRQ. HMC automatically reports this activity to the Fund Office. You don't have to return a form to the Fund Office, but must return it to HMC.
View the online health benefits video	**Gold & Silver:** $125 **Platinum & Platinum Plus:** $150	Watch a 20-minute online video about your medical benefits. You will learn more about how the HRA works, the Healthy Activities, the importance of health screenings, and how the Indemnity PPO Medical Plan works. Access the video through **scufcwfunds.com**. You can view it on a computer, a tablet or a mobile phone. When the video finishes, you'll be prompted to enter your UFCW Family ID number, which is on your medical ID card. For help, contact the Fund Office or your Union Local. Once you submit your information online, this activity is automatically reported to the Fund Office. You don't have to return a form or other paperwork.
Get an annual physical	**Gold & Silver:** $125 **Platinum & Platinum Plus:** $150	Once you complete your physical, this activity is processed through the Fund's claims system, which will trigger your HRA contribution.

Health Activity	How Much You Earn for Your HRA	Steps to Take to Get Credit for your Healthy Activity
Get certain preventive health care services	**Gold & Silver:** $125 per service **Platinum & Platinum Plus:** $150 per service	You receive HRA funding for each of these services (but remember, there is a maximum you can earn for your HRA): • An annual flu shot • Colonoscopy • PSA test (for men) • Mammogram (for women) • Pap smear (for women) Your service(s) are processed through the Fund's claims system. This should trigger your HRA contribution. However, if you receive these services from a clinic or other facility (e.g., your Spouse gets a flu shot at work), return the Preventive Healthcare Services Form to the Fund Office (available online at **scufcwfunds.com** or from the Fund Office).
Get a healthy screening (Your individual results are confidential; they will *not* be shared with your Employer or Union).	**Gold & Silver:** $125 **Platinum & Platinum Plus:** $150	A health screening can help identify potential risks that lead to Illness. Your Healthcare Practitioner will be able to discuss these risks with you. Your screening will include the following health-related tests and measurements. You will give a blood sample that measures: • Total cholesterol • Low-density lipoprotein cholesterol (LDL) • High-density lipoprotein cholesterol (HDL) • Triglycerides • Fasting blood sugar Your healthcare professional will also review: • Use of nicotine • Height • Weight • Resting pulse rate • Waist measurement You can get a screening through your doctor, or a participating in-store pharmacy. The Fund covers the cost for your health screening at 100%, if the screening is done at a PPO Provider. If you visit a PPO Provider, be sure to tell the office to code your visit and lab work as "preventive." Depending on where you decide to get your screening, follow these steps: **If you get your screening through your doctor — you'll need to return a form to the Fund Office** • Contact your doctor to schedule your screening (ideally, do this with your annual physical). Give the **Health Screening Form** (available at **scufcwfunds.com**) to your doctor. Ask your doctor to complete it. Then, it's up to you to return it to the Fund Office. The form is also available from the Fund Office or online at **scufcwfunds.com**. **If you get your screening through a participating in-store pharmacy — no form is required. Reporting to the Fund is automatic. To find a pharmacy and schedule your appointment:** • Kroger (Ralphs/Food4Less) **Phone:** 877-444-9689 **Online:** **www.krogerscreenings.com**
Do up to two healthy "lifestyle activities"	**Gold & Silver:** $125 per activity **Platinum & Platinum Plus:** $150 per activity	• Join and participate in a national/regional weight management program for at least three consecutive months. • Graduate from/complete a tobacco cessation program. • Join a gym, fitness center or other physical activity club/class session (e.g., Pilates, tennis, yoga) for at least a three consecutive-month membership. • Participate in a 5K (or longer) run/walk/bike event (including a biathlon or triathlon). You receive HRA funding when you do at least one of these lifestyle activities. Return the *Healthy Lifestyle Activities* form, available online at **scufcwfunds.com** or from the Fund Office. You also need to provide a receipt or other proof of participation (e.g., Weight Watchers membership fee receipts; bill from a gym; registration receipt for a run/walk/bike event).

HRA Claims

Medical Expenses

When you use a PPO Provider, your Provider will submit claims to the Benefit Fund on your behalf. Payments will be sent directly to Providers who submit claims.

If your Non-PPO Provider does not file a claim on your behalf, you may have to pay that Provider and submit a claim to the Fund Office for reimbursement of the covered amount. PPO Providers have agreed to submit claims for you — another good reason to use them.

Your share of Eligible Medical Expenses, including expenses that count towards your annual Deductible and your Coinsurance, will be paid from your HRA until your account is exhausted.

Prescription Drug Expenses

To use your HRA funds to pay Prescription Drug copays, you must "opt in" by returning an Rx-HRA Option Form to the Fund Office. If the Fund Office has received an Rx-HRA Option Form from you, you will pay the applicable copay for Prescription Drugs when you receive your prescriptions. Then the Fund will use your available HRA balance to reimburse you directly for your eligible Prescription Drug copays until your HRA is exhausted. If you don't opt in by filling out the form, your Prescription Drug copays cannot be reimbursed from your HRA. The Fund will not accept separate claims to reimburse these costs.

If you want the Fund to use your HRA to reimburse your Prescription Drug copays, you must submit a completed Rx-HRA Option Form to the Fund.

Rx-HRA Option Forms are mailed to un-enrolled Participants during Open Enrollment and to new Participants following initial enrollment. If you have already submitted a form to the Fund, you do not have to submit another one unless you want to opt out of HRA Prescription Drug reimbursement. Forms are also available at **scufcwfunds.com**, from the Fund Office, and from your Union Local.

Upon termination of coverage, your account balance in your HRA will be forfeited. This means you will have no access to amounts credited to your HRA beginning with the date your coverage is terminated, and any remaining credits cannot be used to reimburse or pay for any medical expenses incurred after the date your coverage terminates.

Notwithstanding the foregoing, if you regain eligibility for coverage within six months from the date your coverage terminates, your HRA account balance will be reinstated and credited with any HRA credits that existed as of the original forfeiture date. However, if you have a break in-coverage of six months or more (12 months in case of layoff), or if you enroll in an HMO Plan, your HRA will be permanently terminated, and you will not be eligible to have any existing HRA credits reinstated.

If your HRA balance is reinstated, you will not be eligible for reimbursement of expenses incurred during the period of forfeiture.

HRA Exclusions

Your HRA may not be used to reimburse the following expenses:

- Vision, dental or orthodontic expenses.
- Claims submitted prior to the date the Fund credits a healthy activity to your HRA account.
- Premium payments (such as COBRA, self-payment or retiree health and welfare premiums or in the Health Insurance Marketplace).
- Expenses for services that are excluded from the Plan's medical and Prescription Drug programs, such as cosmetic surgery, expenses in excess of the Allowed Amounts, or for non-medical items such as dental expenses or eyeglasses.
- Amounts that exceed the Plan's annual dollar limits, such as for chiropractic care/spinal manipulation. (Example: Depending on your plan option, your chiropractic/spinal manipulation benefit has an $800 or $1,000 annual limit. If you exceed the annual dollar limit, your HRA credits cannot be used to pay for additional chiropractic care/spinal manipulation.)

- Copays for non-preferred MPD drugs and non-formulary drugs that have not been approved by the Fund's pharmacy benefits' manager for a medical exception.
- Penalties, such as for failure to obtain Precertification and the $500 penalty for failure to participate in the Disease Management program.

Under the Americans with Disabilities Act (ADA), the Fund is required to provide a reasonable accommodation or an alternative standard for disabled persons who are unable to participate in the My Health/My Choices Incentive Program. If you think you might be unable to participate due to a disability, contact the Fund Office to discuss a reasonable accommodation or an alternative standard that may be available to you.

The Fund holds the information provided to the Fund Office through the My Health/My Choices Incentive Program in the strictest confidence. The data provided to the Fund triggers HRA contributions for the Healthy Activities you complete. The data also provides the Fund with statistics that can be used to help develop new programs for Participants.

The Trustees, your Employer and your Union do not have access to any of the health information you provide through the My Health/My Choices Incentive Program. They may receive aggregate data about Participants only; they will not receive individual information (that is, medical information that personally identifies you) collected through this program.

The Indemnity PPO Medical Plans

This section applies to Participants who are covered under one of the Indemnity PPO Medical Plans (Silver, Gold, Platinum or Platinum Plus). If you and your eligible Dependents have coverage under one of the HMOs, please see the section of this SPD beginning on page 54 or your Evidence of Coverage (EOC) for a description of your coverage.

How the Indemnity PPO Medical Plans Work — An Overview

- The Indemnity PPO Medical Plans provide benefits for covered preventive care, certain family planning services, and Medically Necessary services and supplies for you and your enrolled dependents.
- Under the Indemnity PPO Medical Plans, you have the freedom to use any licensed Provider you choose, but your benefits are greater when you use Network Providers, also called PPO Providers. When you use out-of-network providers, you will generally spend a lot more of your own money than you would by using PPO Providers.
- Indemnity PPO Medical Plan Benefits include a Health Reimbursement Account (HRA) that helps pay some of your out-of-pocket medical expenses. The HRA can also reimburse your prescription drug expenses, if you opt-in to that part of the program. The Fund automatically makes a contribution to your HRA account every year, and you (and your enrolled Spouse/Domestic Partner) can earn additional contributions by participating in healthy activities.
- When you use a PPO Provider for covered preventive care services, the Plan will pay 100% of the cost of preventive care and immunization services — those services listed in the Plan's current Preventive Care Guidelines (available from the Fund Office) — without tapping your HRA. There is no Deductible and no copay as long as the covered preventive care and immunization services are received from PPO Providers.
- Before the Plan pays benefits other than preventive care benefits, you must generally satisfy the 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 the Allowed Amounts, will apply toward the Non-PPO Deductible.
- After the Deductible is satisfied, the Plan generally pays 75% or 80% of Allowed Amounts (depending on your Plan) if you use a PPO Provider and 50% of the 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 than these percentages.
- For PPO services, once your total medical out-of-pocket expenses have reached the Out-of-Pocket Maximum (OOP Max), the Plan generally will pay 100% of Allowed Amounts for the remainder of the calendar year. Your PPO Deductible counts toward the OOP Max.
- There is no limit on out-of-pocket expenses when you use Non-PPO Providers.

You are strongly encouraged to use only PPO Providers. If you go to a Non-PPO Provider, you will pay a lot more. For a list of PPO Providers, please visit the website listed on the Quick Reference Chart on page 3 or contact the Anthem PPO Network at 855-686-5613.

Covered Charges

You are covered for all or a portion of expenses you incur for most, but not all, medical services and supplies. The expenses which are covered are called "Eligible Medical Expenses." Eligible Medical Expenses are limited to expenses for medical services and supplies that are:

1. **"Medically Necessary,"** but only to the extent that the charges do not exceed the **"Allowed Amounts"** (as the term is defined in the Definitions chapter of this document); and
2. **Not excluded from coverage** (as provided in the Excluded Services and Limitations chapter of this document); and
3. **Not in excess of a maximum Plan benefit** as shown in the Schedule of Medical Benefits; and
4. **For the diagnosis or treatment of an Injury or Illness** (except where wellness/preventive services are payable or if specifically covered under the Plan, as noted in the Schedule of Medical Benefits in this document).

Generally, **the Plan does not reimburse all of your Eligible Medical Expenses**. Usually, you will have to satisfy a Deductible and pay coinsurance and/or copayments toward your Eligible Medical Expenses.

Medical Expenses That Are Not Covered

The Plan will not pay or reimburse you for any expenses that are not Eligible Medical Expenses. That means you are responsible for paying the full cost for services and supplies that are determined to not be Medically Necessary, or are in excess of the Allowed Amount, are not covered by the Plan, or are in excess of a maximum benefit.

Retrospective (Post-Service) Review to Determine Medical Necessity

Health Claims for medical services or supplies that were not reviewed for Precertification or concurrent review may be subject to retrospective review to determine if the services or supplies were Medically Necessary. If the Utilization Management (UM) company determines that services or supplies were not Medically Necessary, **no benefits will be provided by the Plan for those services or supplies**.

Choice of Providers

The Indemnity PPO Medical Plans do not require the selection or designation of a primary care provider. When you need medical care, you have a choice as to whether to use PPO Providers or Non-PPO Providers. PPO Providers are in-network. Non-PPO Providers are out-of-network. As a general rule, you will save money by using PPO Providers.

PPO Providers (In-Network)

If you receive medical services or supplies from PPO Providers, you will have fewer out-of-pocket expenses. PPO Providers have agreed to accept a negotiated fee for covered services.

Advantages of Using PPO Providers

- Your annual Deductible is lower.
- The Plan pays a greater share of your Eligible 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 pre-approvals, Precertification and hospital reviews.

Non-PPO Providers (Out-of-Network)

Refers to Providers who are not contracted with the Plan's PPO network. Non-PPO Providers can charge whatever they want for services, as they have not agreed to a negotiated rate. The fees charged by Non-PPO Providers may be higher than the Plan's Allowed Amount. When that happens, you are responsible for your 50% coinsurance plus any charges above the Plan's Allowed Amount (this is known as Balance Billing). To avoid Balance Billing, Participants should use PPO Providers.

Out-of-Area Benefits

If there are no PPO Providers available to provide the covered Medically Necessary service within 40 miles of your home, the Fund pays "Out-of-Area" benefits for the covered medically necessary service provided by a Non-PPO Provider. Out-of-Area benefits are paid by the Fund at the percentage cost-sharing that would otherwise be applicable to a PPO Provider. However, Out-of-Area Non-PPO Providers **may charge more than the Fund's Allowed Amount and may Balance Bill you** for any charges above the Allowed Amount.

Deductibles

The Deductible is the amount of Eligible Medical Expenses you must pay each Calendar Year before the Plan begins to pay benefits. There are separate Deductibles for PPO and Non-PPO covered services. **Note that these Deductibles are *not* interchangeable, meaning you may not use expenses for PPO services to meet a Non-PPO Deductible and vice versa.**

Each calendar year, you (and not the Plan) are responsible for paying your covered expenses until you satisfy the annual Deductible and then the Plan begins to pay benefits. There are two types of annual Deductibles: Individual and Family.

- The **Individual Deductible** is the maximum amount one Participant has to pay toward covered expenses before Plan benefits begin for that Participant.
- The **Family Deductible** is the maximum amount that a family of two or more Participants is responsible for paying before the Plan begins to pay covered expenses for everyone in the family (covered Employee and Dependents) 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.

The Fund automatically uses your available HRA balance to pay medical claims it receives before your annual Deductible is satisfied. If your HRA balance reaches zero before your

Deductible is satisfied, you are responsible for paying the rest of your Deductible out of your own pocket.

- Eligible Medical Expenses are applied to Deductibles in the order in which claims are processed by the Plan.
- Deductibles under this Plan are accumulated on a Calendar Year basis.

Expenses not subject to Deductibles: Certain Eligible Medical Expenses are not subject to the Deductible. See the Schedule of Medical Benefits to determine which Eligible Medical Expenses are not subject to deductibles. For instance, PPO preventive care benefits and outpatient Prescription Drug benefits are not subject to the Deductible.

Coinsurance

Once you've met your annual Deductible, the Plan generally pays a percentage of the Allowed Amounts (as defined on page 100), and you are responsible for paying your share. The part you pay is called coinsurance. For example, if the Plan pays 80% of an Allowed Amount, you are responsible for 20% coinsurance. If you use PPO Providers, you will have substantially less out-of-pocket coinsurance.

- When you use PPO Providers, the Plan generally pays 75% to 80% of Allowed Amounts (depending on your Plan), and you pay the remaining 25% or 20% as your coinsurance.
- When you use Non-PPO Providers, the Plan generally pays 50% of the Allowed Amount. Non-PPO Providers often charge more for services than the Fund's Allowed Amount. When that happens, you are responsible for paying your 50% coinsurance plus 100% of charges that exceed the Plan's allowance.

The Medical Out-of-Pocket Maximum

The Indemnity PPO Medical Plans have an individual and family Out-of-Pocket maximum limit ("OOP maximum" or "Out-of-Pocket limit") on the amount you will have to pay out of your own pocket for medical benefits. The medical Out-of-Pocket limit applies only to expenses from PPO Providers and Emergency Services from Non-PPO Providers.

- The Out-of-Pocket limits accumulate on a Calendar Year basis.
- Out-of-pocket expenses are applied to the Out-of-Pocket maximum in the order in which eligible claims are processed.
- Cost sharing for all covered family members accumulates to the family Out-of-Pocket limit; however, no one individual in the family will incur out-of-pocket expenses greater than the individual OOP maximum.
- Each calendar year, once the Out-of-Pocket maximum is reached, the Plan will pay 100% of most Eligible Medical Expenses from PPO Providers (***except for*** the out-of-pocket expenses you always pay, listed below) that are incurred during the rest of the calendar year.

Expenses that You always pay and that do not accumulate to the Out-of-Pocket maximum: You (and not the Plan) are responsible for paying the following expenses ***and*** these expenses do not accumulate towards the individual or family medical OOP maximum (nor are they paid at 100% when the OOP maximum is met):

- Premiums (also called "contributions to premium").
- Expenses for services or supplies that are not covered by the Plan.
- Charges in excess of the Allowed Amount.
- Charges in excess of the Plan's maximum benefits, or in excess of any Plan limitations.
- Any amounts you have to pay because you failed to obtain Precertification or comply with the Utilization Management Program (see page 48).
- Penalties for failure to comply with the requirements of the disease management program.
- Expenses for outpatient prescription drugs, except certain injectables (addressed separately in the Prescription Drug Chapter beginning on page 39).
- Expenses for dental, orthodontic and vision benefits.
- Your share of expenses from Non-PPO Providers, except for Emergency Services.

Please note, the Plan also has a Prescription Drug Out-of-Pocket Maximum, discussed in the Prescription Drug section beginning on page 39.

Special Rules for Hospitalization

All hospital stays, except for Emergency Services and maternity stays, must be pre-approved (called "Precertification") under the plan's hospital review procedures. PPO Providers will handle this for you. If you use Non-PPO Providers, you are responsible for obtaining Precertification. If you don't obtain Precertification or comply with the Plan's other hospital review procedures, Plan benefits may be reduced or denied. See page 48 for more information about Utilization Management and penalties that apply if you fail to obtain Precertification.

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 or an annual allowance. The Plan will not pay more than the limit or allowance. Please refer to the excluded services and limitations beginning on page 52.

Time Limit for Initial Filing of Health Claims

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

If a PPO Provider does not file a claim on time, the Provider can bill you only for the copayment or coinsurance you would have paid if the Provider had filed on time.

Schedule of Medical Benefits

A schedule of the Plan's medical benefits appears on the following pages in a chart format. We have outlined Deductibles, Out-of-Pocket maximums and specific covered services and exclusions. Hospital services (inpatient) and Physician and Health Care Practitioner services are listed first because these services are generally used the most. They are followed by descriptions, appearing in alphabetical order, of other benefits for specific healthcare services and supplies that are frequently subject to limitations and exclusions.

Please note, the Chart on the next page does not contain all exclusions and limitations of the Plan. Please see the Excluded Services and Limitations Chapter for more information.

Schedule of Medical Benefits

See also the Exclusions and Definitions sections of this document for important information.
Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
Annual Deductible		$1,000/person $2,000/family	$1,200/person $2,400/family	$1,000/person $2,000/family	$1,200/person $2,400/family	$1,000/person $2,000/family	$1,200/person $2,400/family	$1,000/person $2,000/family	$1,200/person $2,400/family
Out-of-Pocket Maximum (Medical) Includes PPO Deductible	The following expenses do not accumulate towards the medical OOP Maximum (nor are they paid at 100% when the OOP Maximum is met): premiums (also called "contributions to premium"), expenses for services or supplies that are not covered by the Plan, charges in excess of the Allowed Amount, charges in excess of the Plan's maximum benefits, or in excess of any Plan limitations, any amounts you have to pay because you failed to obtain Precertification or comply with the utilization management program (see page 48), penalties for failure to comply with the requirements of the disease management program, expenses for outpatient prescription drugs, except certain injectables (addressed separately in the Prescription Drug Chapter beginning on page 39), expenses for dental, orthodontic and vision benefits, your share of all expenses for medical services or supplies obtained from Non-PPO Providers, except for Emergency Services provided by a Non-PPO Provider.	$3,500/person $7,000/family	None	$3,500/person $7,000/family	None	$2,500/person $5,000/family	None	$2,500/person $5,000/family	None
Hospital Services (Inpatient) 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. **See next row for inpatient Hospital benefits for Total Hip and Knee Replacements.**	• **If you use an Out-of-Area Hospital or Non-PPO Hospital, you need to call 800-274-7767 for Precertification from Anthem Blue Cross (PPO Providers will automatically handle this for you).** • **For Out-of-Area and Non-PPO Providers, there is a 20% benefit reduction for failure to obtain Precertification. This penalty cannot be paid from HRA funds.** • If your hospital admission was the result of an Emergency Medical Condition, Anthem Blue Cross must be notified of the Hospital admission within 48 hours of your admission. • The Plan does not cover Hospital admissions and surgeries that are not Medically Necessary. • Personal items provided in a Hospital are not covered. • Routine nursery care that is billed separately for a newborn in a Hospital is not covered. • Benefits for inpatient hospitalization for Total Hip and Knee Replacements are subject to limitations described in the next row.	75%	50%	75%	50%	80%	50%	80%	50%

Schedule of Medical Benefits (continued)

See also the Exclusions and Definitions sections of this document for important information.

Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
Hospital (Inpatient Knee/ Hip Replacement Surgery) Covered Services include: • Hospital Room with two or more beds unless a private room is determined to be Medically Necessary. • Operating room. • Lab/x-ray/diagnostic services. • Drugs, medicines, oxygen, blood and blood products given to the patient during the Hospital stay. **Please also see the Ambulatory (Outpatient) Surgery Facility row for benefits for Total Hip and Knee Replacement performed in an Ambulatory Surgery Facility.**	• **If you use an Out-of-Area Hospital or Non-PPO Hospital, you need to call 800-274-7767 for Precertification from Anthem Blue Cross (PPO providers will automatically handle this for you).** • **For Out-of-Area and Non-PPO providers, there is a 20% benefit reduction for failure to obtain Precertification. This penalty cannot be paid from HRA funds.** • The $30,000 Allowed Amount applies only to Hospitals in the state of California. Any surgery outside the state of California will be subject to normal surgery benefits. • Have your surgery done at a PPO Designated Facility in order to receive the highest possible benefit reimbursement and lowest out-of-pocket costs. • Personal items provided in a Hospital are not covered. • **If you use a non-designated Hospital, you will be responsible for your coinsurance plus any charges above $30,000, even if you use a PPO Hospital** (and that amount will not count toward your Out-of-Pocket limit).	Designated Hospital or Out-of-Area Hospital: 75% Non-designated PPO Hospital 75% (Allowed Amount limited to $30,000 per confinement)	50% (Allowed Amount limited to $30,000 per confinement)	Designated Hospital or Out-of-Area Hospital: 75% Non-designated PPO Hospital 75% (Allowed Amount limited to $30,000 per confinement)	50% (Allowed Amount limited to $30,000 per confinement)	Designated Hospital or Out-of-Area Hospital: 80% Non-designated PPO Hospital 80% (Allowed Amount limited to $30,000 per confinement)	50% (Allowed Amount limited to $30,000 per confinement)	Designated Hospital or Out-of-Area Hospital: 80% Non-designated PPO Hospital 80% (Allowed Amount limited to $30,000 per confinement)	50% (Allowed Amount limited to $30,000 per confinement)
Physician and Other Health Care Professional Services • Benefits are payable for professional fees when covered services are provided by a Physician or other covered Health Care Practitioner in an office, home, Hospital or other health care facility. • See the Emergency Room, Urgent Care Facility row for payment to Providers in an emergency room.	• **Please note: ALL podiatry surgeries require Precertification, and you must use a Podiatry Plan, Inc. Provider.** • **Foot orthotics can be obtained from any licensed Provider.** • **See the Podiatry row in this Schedule of Benefits.**	75%	50%	75%	50%	80%	50%	80%	50%
Acupuncture/Acupressure	• There is a combined benefit limit for chiropractic/spinal manipulation, acupuncture and acupressure services for each covered person. Only those services listed in the Schedule of Allowances are covered (see page 107. Also available online at **scufcwfunds.com**). • Benefits payable are a percentage of the allowance in the Schedule of Allowances	75% Maximum benefit of $800 per person per Calendar Year		75% Maximum benefit of $800 per person per Calendar Year		80% Maximum benefit of $1,000 per person per Calendar Year		80% Maximum benefit of $1,000 per person per Calendar Year	

Schedule of Medical Benefits (continued)

See also the Exclusions and Definitions sections of this document for important information.

Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
Accident Benefit A benefit is payable for covered services rendered within 90 days of an accident as a result of the accident (applied without respect to whether the Participant was covered under the Plan at the time of the accident).	The Plan will use the accident benefit to reimburse your Deductible or out-of-pocket expenses for covered services resulting from the accident before using available HRA Funds.	$300 benefit		$300 benefit		$500 benefit		$500 benefit	
Ambulance Services • Ground vehicle emergency transportation to the nearest appropriate facility as Medically Necessary for treatment of an Emergency or acute Illness. • Air/sea emergency transportation to the nearest appropriate facility 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.	• Ambulance services are covered for Medically Necessary transportation to or from the Hospital only when the 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.	75%	75%	75%	75%	80%	80%	80%	80%
Bariatric (Weight Loss) Surgery	• Bariatric surgery may be covered if preauthorized as Medically Necessary by Anthem. Please refer to Hospital or Ambulatory Surgery Facility rows for more information on these benefits.	75%	50%	75%	50%	80%	50%	80%	50%
Chiropractic Services/Spinal Manipulation Includes visits, therapy, adjustments and x-rays.	• There is a combined benefit limit for chiropractic/spinal manipulation, acupuncture and acupressure services for each Participant. Only those services listed in the Schedule of Allowances are covered (see page 107. Also available online at **scufcwfunds.com**.). • Benefits payable are a percentage of the allowance in the Schedule of Allowances	75% up to $800 per person per Calendar Year		75% up to $800 per person per Calendar Year		80% up to $1,000 per person per Calendar Year		80% up to $1,000 per person per Calendar Year	

Schedule of Medical Benefits (continued)

See also the Exclusions and Definitions sections of this document for important information.

Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
Emergency Room, Urgent Care Facility • Hospital emergency room (ER) • Urgent Care facility	• There is no Precertification requirement for Emergency Services. However, if you require emergency hospitalization, Anthem Blue Cross must be notified of the Hospital admission within 48 hours of your admission. • Do not use an emergency room for routine office visits or non-emergency situations or benefits may be denied. • 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.	75%	75%	75%	75%	80%	80%	80%	80%
Employee Member Assistance Program (EMAP) Benefits **(Mental Health and Substance Abuse Treatment)** The EMAP is administered by HMC HealthWorks (HMC). Before receiving treatment, you are strongly encouraged to call HMC at 800-461-9179. HMC will coordinate your care and make sure you see PPO Providers. The EMAP provides inpatient and outpatient mental/Behavioral Health and substance abuse treatment, including therapy and residential treatment. The program also helps you and your Dependents resolve personal problems in the early stages. You can get help with stress, aging, anxiety, family issues, grief/loss, relationships, marriage, alcohol/drug abuse and/or depression. • **Outpatient services** include office visits and necessary Psychological (Psychiatric) Testing. • **Other Services:** Partial day care/partial hospitalization or intensive outpatient program (IOP) care.	**For mental health and substance abuse services, the PPO network of Health Care Providers and facilities is provided by HMC HealthWorks (HMC).** To receive PPO level benefits, you must use an HMC-contracted provider. You are encouraged to call HMC before seeking treatment, to ensure you get the highest level of benefits. • **Precertification is required for in-patient Hospital admissions (except Emergency admissions), residential treatment, intensive outpatient treatment and partial day hospitalization/partial day care services.** • **When HMC coordinates the admission, Precertification is automatic. However, before you are admitted to an Out-of-Area or Non-PPO Hospital or other facility, you need to call 800-461-9179 to get Precertification from HMC. If you do not obtain Precertification from HMC, your benefits will be reduced by 20% (this penalty cannot be paid by HRA funds).** Outpatient Prescription Drugs are payable under the Prescription Drug Program. See page 39 of this SPD.	75%	50%	75%	50%	80%	50%	80%	50%

Schedule of Medical Benefits (continued)

See also the Exclusions and Definitions sections of this document for important information.

Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
Family Planning, Reproductive, Contraceptive Services • Sterilization services (e.g., vasectomy, tubal ligation, implants). • Contraceptive devices. • Infertility — limited to initial exam and diagnostic services.	• No coverage for reversal of sterilization procedures. • When a generic contraceptive device is available, only the generic is covered at no cost-sharing, unless the generic is medically inappropriate. • Treatment of infertility is limited to initial exam and diagnostic services. • Contraceptive drugs, such as birth control pills, are covered under the Prescription Drug Program.	**Female sterilization and FDA-approved contraceptive devices:** 100%, deductible waived **All others:** 75%	50%	**Female sterilization and FDA-approved contraceptive devices:** 100%, deductible waived **All others:** 75%	50%	**Female sterilization and FDA-approved contraceptive devices:** 100%, deductible waived **All others:** 75%	50%	**Female sterilization and FDA-approved contraceptive devices:** 100%, deductible waived **All others:** 75%	50%
Home Health Care and Home Infusion Therapy 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.	• Nursing care in the home limited to 400 visits per Participant per lifetime. • Custodial care and Homemaker services not covered.	75%	50%	75%	50%	80%	50%	80%	50%
Hospice Hospice services include inpatient Hospice Care and outpatient home hospice for a terminally ill patient.	• **Precertification from the PPO Case Manager is required, or there is no coverage.** • **If you use an Out-of-Area or Non-PPO Provider, you need to call 800-274-7767 to obtain Precertification from Anthem Blue Cross (a PPO provider will automatically handle this for you).**	75%	50%	75%	50%	80%	50%	80%	50%
Laboratory Services (Outpatient) Includes technical and professional fees	• Covered only when ordered by a Physician or Health Care Practitioner. • Inpatient laboratory services are covered under the Hospital services section of this Schedule. • Some laboratory services may be payable as Preventive Care.	75%	50%	75%	50%	80%	50%	80%	50%

Schedule of Medical Benefits (continued)

See also the Exclusions and Definitions sections of this document for important information.

Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
Maternity Services Hospital and Birthing Center charges and Physician and Certified Nurse Midwife fees. The following maternity services are payable as Preventive Care Services: • Breastfeeding equipment (breast pump) and supplies needed to operate the pump, as outlined in the Durable Medical Equipment row of this Schedule. • In conjunction with birth, the Plan pays for lactation support and counseling (including breastfeeding classes) by a trained provider during pregnancy and/or in the postpartum period at 100%, no deductible, when provided by a PPO provider. Under this Plan, a trained provider is a breastfeeding or lactation educator.	• Maternity care is covered for a female Employee or Spouse or Domestic Partner only. **No coverage is provided for maternity/delivery expenses of Dependent Children** (except for certain preventive screening services mandated by ACA). • Surrogate pregnancies and all related charges (both when the surrogacy is for a Plan Participant and when a Plan Participant is the surrogate) are not covered. • Under federal law, group health plans 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. The Plan may pay for a shorter stay if the attending Provider, after consultation with the mother, discharges the mother or newborn earlier. In any case, the Plan 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:** 100%, Deductible waived **All other:** 75%	50%	**Lactation support and counseling:** 100%, Deductible waived **All other:** 75%	50%	**Lactation support and counseling:** 100%, Deductible waived **All other:** 75%	50%	**Lactation support and counseling:** 100%, Deductible waived **All other:** 75%	50%

Schedule of Medical Benefits (continued)

See also the Exclusions and Definitions sections of this document for important information.

Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
Medical Supplies & Equipment Coverage is provided for Medically Necessary Durable Medical Equipment (DME): • DME must be ordered by a Health Care Practitioner, be of no further use when medical need ends, be usable only by the patient and manufactured specifically for medical use. • Diabetic supplies (e.g., a diabetic glucose meter, insulin pump and related necessary supplies) and other Medically Necessary diabetes DME. • Oxygen and its administration, blood and blood products (and their administration), medical prosthetics, splints, casts, other supplies, and chemotherapy/radiation/antigens. • Infusion drugs/injectable drugs (except insulin). • For the duration of breastfeeding, coverage is provided for one standard manual or electric breast pump (plus supplies to operate the breast pump). Coverage is provided for **nondurable supplies** dispensed/used by a Health Care Practitioner, such as: • Dialysis supplies, Colostomy and ostomy supplies. • Medical supplies/devices, including sterile surgical supplies used immediately after surgery. • Supplies needed to operate or use covered medical supplies or corrective appliances. • Supplies needed by skilled home health or home infusion personnel, but only during the course of their services.	• Equipment for exercise, environmental control or for the patient's comfort or hygiene is not covered. • Rental charges that exceed the reasonable purchase price of the equipment are not covered. **Maximums for Silver/Gold Plans:** • Hearing aids: During any 36-month period, there is a maximum benefit of $475 for one aid or $630 for two aids. • Orthopedic shoes are subject to a $235 annual maximum. • Orthotics: $125 annual maximum. • Health aids (except crutches): $95 annual maximum. **Maximums for Platinum/Platinum Plus Plans:** • Hearing aids: During any 36-month period, there is a maximum benefit of $840 for one aid or $1,050 for two aids. • Orthopedic shoes are subject to a $315 annual maximum. • Orthotics: $210 annual maximum. • Health aids (except crutches): $160 annual maximum. **Nondurable supplies:** Coverage is provided for up to a 31-day supply of home/personal use and may be refilled if Medically Necessary. • A blood glucose monitor is covered every two years. • Insulin is covered under the Prescription Drug Program.	**Breast Pump:** 100%, deductible waived **All others:** 75%	50%	**Breast Pump:** 100%, deductible waived **All others:** 75%	50%	**Breast Pump:** 100%, deductible waived **All others:** 75%	50%	**Breast Pump:** 100%, deductible waived **All others:** 75%	50%
Ambulatory (Outpatient) Surgery Facility Ambulatory (Outpatient) Surgery Facility (e.g. surgicenter, same day surgery, outpatient surgery). Physician/surgeon fees are payable under the Physician and Other Health Care Practitioner Services row on page 30.	• There is a $1,000 per surgery benefit maximum at a Non-PPO facility.	75%	50% up to a maximum of $1,000	75%	50% up to a maximum of $1,000	80%	50% up to a maximum of $1,000	80%	50% up to a maximum of $1,000

Schedule of Medical Benefits (continued)

See also the Exclusions and Definitions sections of this document for important information.

Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
Podiatry Services Podiatry Care 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 Podiatry Plan, Inc. and provided by a Podiatry Plan Provider.	• **Please note: ALL podiatry surgery requires Precertification by Podiatry Plan, Inc. or there is no coverage.** • Podiatry benefits are provided through Podiatry Plan, Inc. • You are required to use Podiatry Plan Providers or there is no coverage. You can obtain a list of Podiatry Plan Providers by calling 800-367-7762. Podiatry surgery not precertified by Podiatry Plan is not covered (even if a Podiatry Plan Provider is utilized). • Please contact the Fund Office for possible Out-of-Area benefits.	75%	Not covered	75%	Not covered	80%	Not covered	80%	Not covered
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 the Preventive Care benefits). • Technical and professional fees associated with diagnostic and curative radiology services, including radiation therapy.	• Covered only when ordered by a Physician or Health Care Practitioner and Medically Necessary.	75%	50%	75%	50%	80%	50%	80%	50%

Schedule of Medical Benefits (continued)

See also the Exclusions and Definitions sections of this document for important information.

Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	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. These benefits will be provided subject to the same deductibles and co-insurance applicable to other medical and surgical benefits provided under the Plan.	See the exclusions related to Cosmetic Treatment in the Exclusions chapter.	75%	50%	75%	50%	80%	50%	80%	50%
Rehabilitation Services Coverage for physical, speech and inhalation therapy.	**Precertification is required for inpatient rehabilitation care. For admission to an Out-of-Area or Non-PPO Provider, you need to call 800-274-7767 for Precertification from Anthem Blue Cross (a PPO Provider will automatically handle this for you). There is a 20% benefit reduction for non-compliance (and this penalty cannot be paid from HRA funds).**	75%	50%	75%	50%	80%	50%	80%	50%
Skilled Nursing Facility (SNF) • Services must be ordered by a Physician or Healthcare Practitioner and must be Medically Necessary. • Must follow a hospitalization.	• **If you use an Out-of-Area or Non-PPO Provider, you need to call 800-274-7767 for Precertification from Anthem Blue Cross (a PPO Provider will automatically handle this for you). For Out-of-Area or Non-PPO Providers, there is a 20% benefit reduction for non-compliance (and this penalty cannot be paid from HRA funds).** • The benefit for room and board at a Non-PPO or Out-of-Area facility is limited to 50% of the semi-private room rate at the Hospital from which the patient was discharged. • Custodial care is not covered.	75%	50%	75%	50%	80%	50%	80%	50%

Schedule of Medical Benefits (continued)

See also the Exclusions and Definitions sections of this document for important information.

Important: Non-PPO and Out-of-Area Providers may charge more than the Allowed Amount. You are responsible for your coinsurance plus any charges above the Allowed Amount.

Benefit Description	Explanations and Limitations of Benefits	Silver Plan		Gold Plan		Platinum Plan		Platinum Plus Plan	
		PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO	PPO and Out-of-Area	Non-PPO
TMJ Services Temporomandibular Joint (TMJ) dysfunction or syndrome.	If you use a Non-PPO Provider, TMJ surgery benefits are limited to the following dollar maximum per period of disability: • **Silver and Gold Plans:** $2,100 • **Platinum:** $2,625 • **Platinum Plus:** $2,625	75%	50%	75%	50%	80%	50%	80%	50%
Transplants (Organ and Tissue) Coverage is provided only for eligible services directly related to Medically Necessary and non-Experimental transplants along with the facility and professional services, FDA approved drugs, and Medically Necessary equipment and supplies.	• **If you use an Out-of-Area or Non-PPO Provider, you need to call 800-274-7767 for Precertification from Anthem Blue Cross (a PPO Provider will automatically handle this for you). For Out-of-Area or Non-PPO Providers, there is a 20% benefit reduction for non-compliance (and this penalty cannot be paid from HRA funds).** • The transplant recipient must be a Plan Participant for any transplant to be covered. • If both the donor and recipient are covered Plan Participants, the transplant will be covered at a PPO, Non-PPO or Out-of-Area Hospital. • If the donor is not a Plan Participant, expenses of the donor at a Non-PPO Hospital are not covered. • Donor search fees are limited to $10,000 per transplant.	75%	50%	75%	50%	80%	50%	80%	50%
Vision Services Vision benefits are automatically included with medical coverage at **no additional cost to you**. You may opt-out by calling the Fund Office and completing the proper form. Dropping your vision coverage **will not reduce your weekly payroll deductions**.	• Payment for prescription lenses will be made only if no more than 12 months have elapsed between the date of the last vision examination and the date glasses or contact lenses are ordered, except when a lens change is required following eye surgery. • Your HRA Funds cannot be used for vision expenses.	**Age 0–18:** Plan pays up to $125 per Child per Calendar Year. The $125 annual limit does not apply to vision screenings and exams, which are essential pediatric services. Any additional charges, including those for frames and lenses, are subject to the annual dollar maximum regardless of age. **Ages 19 and up:** Plan pays up to $125 per person per Calendar Year for exam and materials.		**Age 0–18:** Plan pays up to $150 per Child per Calendar Year. The $150 annual limit does not apply to vision screenings and exams, which are essential pediatric services. Any additional charges, including those for frames and lenses, are subject to the annual dollar maximum regardless of age. **Ages 19 and up:** Plan pays up to $150 per person per Calendar Year for exam and materials.				
Preventive Care for Men, Women and Children The preventive care services covered under 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 share for the diagnostic or therapeutic services but not for the preventive care services. When a preventive care visit turns into a diagnostic or therapeutic service in the same visit, the diagnostic or therapeutic cost share will apply. The diagnosis and procedure codes submitted by the provider determine whether a service is considered preventive care. • 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 routine 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 visit scufcwfunds.com. These Guidelines are updated on an annual basis and describe your preventive care benefits in 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, preventive care services are generally covered at 50% 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 Plan will cover the service when performed by a Non-PPO Provider without cost sharing. **Please note:** you must use a PPO Provider if one is available in your geographic area. See the row entitled "Over-the-Counter Drugs" for information on payment for certain preventive care drugs in compliance with the ACA.								

Prescription Drug Program

Please note that the Prescription Drug benefits and exclusions outlined in this chapter apply to ALL Participants whether enrolled in an Indemnity PPO Medical Plan, the Kaiser Permanente HMO or the Anthem HMO Plan, except that the Market Priced Drug Program (MPD Program) does NOT apply to Kaiser Participants.

The Fund has contracted with OptumRx to administer the Fund's outpatient prescription drug program. **You *must* fill your prescriptions at a Participating Pharmacy or there is no coverage available.** The only exception to this is coverage for certain emergency situations.

You may use the pharmacy located in any of the following chain stores in California:

- Pavilions
- Ralphs
- Rite-Aid
- Safeway
- Sav-on Pharmacy located in Albertsons
- Vons
- Gelson's

For a complete list of all Participating Pharmacies, including certain CVS pharmacies, visit **www.optumrx.com**. You may also use the OptumRx Mail Order Program for drugs that you take on a long-term basis.

Your cost for prescription drugs varies depending on whether you fill your prescription at a Participating Pharmacy, whether you are participating in the Disease Management Program, and whether the prescription is:

- A generic or a brand name drug;
- A formulary or non-formulary drug;
- A Preferred or Non-Preferred Drug under the Market Priced Drug (MPD) Program (not applicable to Participants in the Kaiser HMO Plan);
- A 30-day or 90-day supply; or
- A long-term maintenance medication for treatment of select conditions (therapeutic classes of drugs used for treating hypertension, high cholesterol, diabetes, including related supplies, asthma, including related supplies, osteoporosis or glaucoma.

Copays or Copayments

A copay or copayment is a fixed dollar amount you are responsible for paying when you purchase a covered Prescription Drug from an in-network pharmacy (referred to as a Participating Pharmacy).

Your Prescription Drug copays can be reimbursed from your available HRA balance — **if you have submitted an Rx-HRA Option Form to the Fund Office**.

Non-Participating Pharmacies

The Fund does not cover Prescription Drugs obtained at a Non-Participating Pharmacy, except in the case of an emergency. There is an additional copay of $25 for each emergency prescription filled at a Non-Participating pharmacy.

90-Day Supply for Maintenance Drugs

The Fund generally provides benefits for up to a 30-day supply of drugs to treat an acute condition. Maintenance Drugs are used to treat chronic or long-term conditions that require regular, daily use of medicines. Examples of maintenance drugs are those used to treat high blood pressure, asthma and diabetes.

If you take a maintenance drug, you may use the OptumRx Mail Order Program or any Network Pharmacy that participates in the Plan's 90-day maintenance program. When you do so, you can receive a 90-day supply of your maintenance medicine for an amount equal to just two copayments for all covered maintenance drugs except Non-Preferred MPD Drugs.

The OptumRx Mail Order Program provides a convenient way to fill your maintenance medications. Through the mail order prescription service, your prescription is mailed directly to your home. Call OptumRx customer service at 888-715-7573 for more information regarding the mail order program. You can also visit the OptumRx web site, **www.optumrx.com**, to order and refill your maintenance prescriptions online.

Certain Maintenance Drugs for Select Conditions at Lower Copays

As an incentive to take your required medication, certain approved maintenance drugs that have been identified as especially effective at treating specific chronic conditions and are approved for long-term therapy have lower copays than normal (and can be obtained in 90-day supplies for a reduced copay equal to twice the 30-day copay). The drugs covered by this special reduced copayment are those Preferred MPD Drugs and Non-MPD Drugs* used to treat the following chronic conditions:

- Hypertension (High Blood Pressure)
- High Cholesterol
- Diabetes (control drugs and supplies)
- Asthma (including related supplies)
- Glaucoma
- Osteoporosis

** Note: Reduced copays are not available for Non-Preferred MPD Drugs. For more information about the MPD Program (applicable to all Participants except Kaiser enrollees) see page 43.*

Coordination of Prescription Drug Benefits

If you or any of your Dependents have coverage under another employer's plan through your Spouse or through other employment, you can use the Prescription Drug Program to cover up to the full cost of a prescription. This option is not available to Participants who have Dual Coverage under the Fund.

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

1. File a claim first with your other medical plan.
2. After you receive payment under the other plan, send the other plan's Explanation of Benefits or an itemized receipt from the pharmacy and a prescription drug claim form to the Fund Office.
3. The Fund will then reimburse you for the copayment you have paid for your prescription plus $1 to reimburse you for postage and copying the claim.

Out-of-Pocket Maximum for In-Network Prescription Drugs

Each Calendar Year, after an individual or family has incurred a specified amount of out-of-pocket expenses for Prescription Drugs as outlined in the chart on the following page, no further copays will be required for most covered Prescription Drugs. As a result, if this Prescription Drug Out-of-Pocket Maximum is reached, the Plan will pay 100% for most of your **covered** Prescription Drugs (except for the out-of-pocket expenses you always pay, listed below). **Please note there is a separate Out-of-Pocket Limit on In-Network medical expenses.**

This Prescription Drug Out-of-Pocket maximum applies to:

- Formulary generic drugs and formulary brand-name drugs;
- Preferred MPD drugs; and
- Non-formulary drugs approved due to a medical exception.

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 Prescription Drug Out-of-Pocket maximum:

- Non-formulary drugs without a PBM-approved medical exception;
- Non-Preferred MPD drugs;
- Most injectable drugs (Note: Most injectable drugs count towards the Medical Out-of-Pocket Maximum); and
- Drugs not purchased at a Participating Pharmacy or through the OptumRx Rx Mail Order program, except in the case of an emergency.

The chart beginning on the following page outlines the Prescription Drug Out-of-Pocket maximums.

Schedule of Prescription Drug Benefits					
	Silver Plan	**Gold Plan**	**Platinum Plan**	**Platinum Plus**	**Your Cost for Non-Preferred MPD Drugs** (for all Plans, except Kaiser HMO)
Prescription Drug Out-of-Pocket Maximum* Your cost for Non-Preferred MPD drugs, and for non-formulary drugs not approved by the PBM for a medical exception do not count toward the Out-of-Pocket Maximum and will not be paid by the Plan at 100% in the event you reach your Prescription Drug Out-of-Pocket Maximum.	$4,400/person $8,800/family	$4,400/person $8,800/family	$5,400/person $10,800/family	**Indemnity PPO:** $5,400/person $10,800/family **Kaiser Permanente HMO:** $6,400/person $12,800/family **Anthem HMO:** $6,400/person $11,300/family	Unlimited
Type of Medication	MPD Prescription Drugs (MPD Program does not apply to Kaiser HMO Participants)				
Formulary MPD Generic Drug	**30-day supply:** Greater of $10 copay or 10% of cost **90-day supply:** $20 copay	**30-day supply:** $10 copay **90-day supply**: $20 copay	**30-day supply:** $10 copay **90-day supply**: $20 copay	**30-day supply:** $10 copay **90-day supply**: $20 copay	You must pay the appropriate copay for your Plan listed to the left **plus** the actual difference in price between the Non-Preferred Drug and the Preferred Drug (if applicable). **Always ask your Pharmacist to verify your cost for every prescription before it is filled.** **Participant submitted claims:** Available only for emergencies and Out-of-Area users. Plan pays the lesser of purchase price or average wholesale price (AWP) less applicable copay(s). There is an additional copay of $25 for each emergency prescription filled at a Non-Participating pharmacy. Amounts over AWP cannot be paid from HRA Funds.
Formulary MPD Brand-Name Drug	**30-day supply:** Greater of $30 copay or 25% of cost **90-day supply**: $60 copay	**30-day supply:** $20 copay **90-day supply:** $40 copay	**30-day supply:** $20 copay **90-day supply:** $40 copay	**30-day supply:** $20 copay **90-day supply:** $40 copay	
Non-Formulary MPD Drug	**30-day supply:** Greater of $50 copay or 50% of cost **90-day supply:** $100 copay	**30-day supply:** $35 copay **90-day supply:** $70 copay	**30-day supply:** $35 copay **90-day supply:** $70 copay	**30-day supply:** $35 copay **90-day supply:** $70 copay	

** Prescription Drug Out-of-Pocket Maximums are subject to change annually. Maximums shown are for 2019 calendar year.*

Schedule of Prescription Drug Benefits					
	Silver Plan	**Gold Plan**	**Platinum Plan**	**Platinum Plus**	**Your Cost for Non-Preferred MPD Drugs** (for all Plans, except Kaiser HMO)
Type of Medication	Non-MPD Prescription Drugs (For conditions not covered by MPD Program)				
Formulary Generic Drug	**30-day supply:** Greater of $10 copay or 10% of cost **90-day supply:** $20 copay	**30-day supply:** $10 copay **90-day supply**: $20 copay	**30-day supply:** $10 copay **90-day supply**: $20 copay	**30-day supply:** $10 copay **90-day supply**: $20 copay	Not Applicable
Formulary Brand-Name Drug	**30-day supply:** Greater of $30 copay or 25% of cost **90-day supply**: $60 copay	**30-day supply:** $20 copay **90-day supply:** $40 copay	**30-day supply:** $20 copay **90-day supply:** $40 copay	**30-day supply:** $20 copay **90-day supply:** $40 copay	
Non-Formulary Drug	**30-day supply:** Greater of $50 copay or 50% of cost **90-day supply:** $100 copay	**30-day supply:** $35 copay **90-day supply:** $70 copay	**30-day supply:** $35 copay **90-day supply:** $70 copay	**30-day supply:** $35 copay **90-day supply:** $70 copay	
Special Therapeutic Classes					
The reduced copays listed in this section are for maintenance medications to treat hypertension, high cholesterol, diabetes (control drugs and supplies), osteoporosis, glaucoma and asthma (including related supplies). The following reduced copays apply to Non-MPD drugs and drugs that are on the MPD "Preferred Drug" list. If your prescription is filled with a drug that is classified as "Non-Preferred" under the MPD program, your cost will be much higher than the copays for the special therapeutic classes shown below because you will be responsible for paying the difference in price between the Non-Preferred Drug and the Preferred Drug as well as the applicable copay.					
Formulary Preferred MPD or Non-MPD Generic Drug	**30-day supply:** $7 copay **90-day supply:** $14 copay				You must pay the appropriate copay for your Plan listed to the left **plus** the actual difference in price between the Non-Preferred Drug and the Preferred Drug (if applicable). **Participant submitted claims:** Available only for emergencies and Out-of-Area users. Plan pays the lesser of purchase price or average wholesale price (AWP) less applicable copay(s). There is an additional copay of $25 for each emergency prescription filled at a Non-Participating pharmacy. Amounts over AWP cannot be paid from HRA Funds
Formulary Preferred MPD or Non-MPD Brand Name Drug	**30-day supply:** $15 copay **90-day supply:** $30 copay				
Non-Formulary Preferred MPD or Non-MPD Drug	**30-day supply:** $25 copay **90-day supply:** $50 copay				

Schedule of Prescription Drug Benefits (continued)		
Type of Medication	**Explanations and Limitations**	**Silver Plan, Gold Plan, Platinum Plan, Platinum Plus Plan**
Preventive Care Drugs Certain preventive care drugs are payable by the Fund **at no charge when purchased at a Participating Pharmacy**.	**For a preventive care drug to be covered by the Plan, the drug must be:** • Obtained through the outpatient Prescription Drug program at a participating network retail pharmacy; and • Presented to the **pharmacist with a prescription for the drug** from your Physician or appropriate Healthcare Practitioner. Brand name drugs will be covered if a generic is medically inappropriate as determined by OptumRx.	**Please contact the Fund Office or see scufcwfunds.com for a copy of the official *Preventive Care Guidelines* (including a description of the preventive drugs that are covered). These Guidelines are updated on an annual basis and describe your preventive care benefits in a "member friendly" format.** No charge if a covered preventive care drug is purchased at a Participating Pharmacy with a prescription. Covered preventive care drugs that are purchased at a Non-Participating Pharmacy are **not covered** and cannot be paid from HRA Funds.

About The Market Priced Drugs (MPD) Program

The **Market-Priced Drug (MPD) program applies to Indemnity PPO and Anthem HMO Medical Plan Participants**. The MPD program helps you and your doctor identify lower cost Prescription Drugs for treating common chronic health conditions. **The MPD program does not apply to Participants enrolled in the Kaiser Permanente HMO Plan.**

The MPD program will help you and your doctor identify lower cost Prescription Drugs for treating some common health conditions. Under the MPD program, **lower cost drugs are called "Preferred Drugs.**" When you use a Preferred Drug to treat a condition included in the MPD program (as outlined below), you and your covered Dependents will pay your regular copayment. However, if you or your covered Dependents use a drug that is not on the Preferred Drug list to treat a condition included in the MPD program (known as a "Non-Preferred" Drug), you pay the applicable brand or generic copay for the Non-Preferred Drug and you ***also*** have to pay the price difference between the Non-Preferred Drug and the Preferred Drug. In some cases, your out-of-pocket cost will be much higher.

Preferred Drugs vs. Non-Preferred Drugs

All drugs must meet the Food and Drug Administration (FDA) standards for safety and effectiveness before they can be sold to consumers. Although they treat the same condition, Preferred and Non-Preferred drugs may have different active ingredients and vary in price. As an example, Simvastatin costs less than Crestor®, but both drugs are FDA approved to safely and effectively treat high cholesterol. Therefore, Simvastatin is designated as a Preferred Drug and your regular copays apply if you fill a prescription for this drug. Crestor® is a Non-Preferred Drug so you will pay your regular copayment plus the difference between the market prices of Crestor® and Simvastatin, if you fill a prescription for Crestor®.

The MPD program covers medications for several common, chronic medical conditions, including:

- High Cholesterol
- Diabetes
- High Blood Pressure
- Depression/Anxiety
- Allergy/Asthma
- Heart Rhythm/Chest Pain
- Muscle Relaxants
- Acid Reflux
- Thyroid
- Inflammatory Conditions
- Pain Management
- Hormone Replacement
- Parkinson's Disease
- Edema
- Additional conditions (e.g., osteoporosis, hair loss, erectile dysfunction)

The Fund's pharmacy benefits management vendor, OptumRx, periodically reviews each Participant's Prescription Drug history. If a Participant is using a Non-Preferred Drug when a Preferred MPD Drug alternative is available, the Participant will receive a personalized letter that outlines the medication affected by this program, the suggested MPD alternative, and estimated savings from switching.

The list of MPD-covered conditions and drugs changes from time-to-time, so be sure to contact OptumRx to verify a drug's status. For a list of your current prescriptions, Preferred Drugs and pricing, visit **www.optumRx.com**, enter the information requested, and click "Submit" to access "My Medicine Cabinet." Have your medical plan ID card with you when you visit the site for the first time — you'll need your member ID from the card to access the site.

What You Need to Do if You Are Prescribed a Non-Preferred Drug

If you are prescribed a Non-Preferred Drug, you and/or your covered Dependents may receive a letter from OptumRx (the Plan's pharmacy benefit manager) if there is a Preferred Drug alternative. The letter will provide each Participant with information about the alternative Preferred Drugs and their estimated costs. If you receive one of these letters from OptumRx, we encourage you to share it with your doctor and ask if a less costly Preferred Drug is right for you. Your doctor knows your full medical history and which drug therapies he/she prefers for you.

You may also access the OptumRx program through the Fund's website to look up your current Prescription Drugs to determine if there is a Preferred Drug alternative. Also, when you need Prescription Drugs in the future, be sure to tell your doctor about the MPD program.

Exception Process

If you and your Physician decide that a Preferred Drug is not right for you, your Physician can complete and return a **Market Priced Drug Exception form** to request that you be permitted to continue using a Non-Preferred Drug under the same plan terms as a Preferred Drug. Typically, exceptions are requested for reasons like the following:

- Your doctor has determined the Preferred Drug doesn't work for you.
- Your doctor has determined that the Preferred Drug won't work with other medications you take.
- Your doctor feels your condition would be better treated with a Non-Preferred Drug.

You or your doctor may call OptumRx 24-hours a day, seven days a week to request an exception. You can also obtain an exception form by visiting the Benefit Fund website at **scufcwfunds.com**. Your doctor must complete a short form and provide to OptumRx evidence of a recognized medical reason for the exception request. If approved, you will pay the applicable copay for the medication but you will not be required to pay the difference between the preferred drug price and the price of your non-preferred medication.

If your request for an exception was approved in the past, the exception will remain in effect for up to one year. If you continue using the Non-Preferred Drug after one year, your prescription will need to be re-reviewed and you will need to request another exception.

MPD Program Examples

The following example illustrates your estimated costs for the Preferred Drug Azelastine HCL (nasal) versus the Non-Preferred Drug Astepro SPR 0.15%.

Preferred Drug (Azelastine HCL (nasal))	**Non-Preferred Drug** (Astepro SPR 0.15%)	**Non-Preferred Drug** (Astepro SPR 0.15% — if an exception is approved by OptumRx)
You pay regular copay: $10 (Plan pays Azelastine price of $38.75 less your copay = $28.75)	**Step 1:** Calculate the difference in cost between the Preferred and Non-Preferred drug: Astepro SPR: $132.48 Azelastine: - $38.75 Total $93.73 **Step 2:** Add the copay + $10 **Your cost**: **$103.73** (Plan still pays Allowed Amount less your copay = $28.75)	**You pay regular copay: $10** (Plan pays Astepro SPR price of $132.48 less your $10 copay = $122.48)

Special Rule for HMO Participants Regarding Injectable Medications

In most cases, if you are enrolled in an HMO and are taking a medication that is administered by injection, the medication will be provided by your HMO. If an injectable drug (other than insulin) is not covered by your HMO, you may submit a request to have it paid through the Fund at 80%. After reaching the Ancillary Benefits Out-of-Pocket maximum (if you are in Kaiser) or the medical out-of-pocket maximum (if you are in the Anthem HMO), injectable drugs will be paid at 100% for the rest of the year. Contact the Fund Office for help on how to submit an injectable drug for reimbursement.

Prescription Drug Exclusions

In addition to the General Excluded Services and Limitations beginning on page 52, the Prescription Drug Program does not pay for:

- Prescriptions dispensed by a licensed Hospital during confinement, except for drugs dispensed by the Hospital pharmacy for "take-home" medication in emergency circumstances.
- Drugs, medications or non-drug items that may be purchased without a Healthcare Practitioner's written prescription, except that diabetic supplies and certain over-the-counter drugs covered under the Plan's preventive care benefits are covered.
- Contraceptive devices (these may be covered under the Indemnity PPO Medical Plan); and over-the-counter contraceptive drugs or methods, except for the drugs or methods covered under the Plan's preventive care benefits. If you are enrolled in an HMO, refer to your Evidence of Coverage (EOC) for coverage or call the Fund Office.
- Injectable immunization agents (these may be covered under the Indemnity PPO Medical Plan), except that certain immunizations received at Participating Pharmacies are covered under the Prescription Drug Program. If you are enrolled in an HMO, refer to your EOC for coverage from the HMO or call the Fund Office.
- Injectable drugs administered or dispensed by a Physician or nurse (these may be covered under the Indemnity PPO Medical Plan). If you are enrolled in an HMO, refer to your EOC for coverage or call the Fund Office.
- Drugs used to promote hair growth.
- Drugs used for the treatment of infertility.
- Drugs that induce abortion.
- Drugs 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.
- Appliances or prosthetics (these may be covered under the Indemnity PPO Medical Plan). If you are enrolled in an HMO, refer to your EOC for coverage or call the Fund Office.
- Lost, stolen, broken or spilled drugs or supplies.
- Services or medications otherwise covered under the Indemnity PPO Medical Plan.
- Tobacco cessation medications (except as covered under the Fund's Preventive Care Guidelines).

Medical Networks — PPO Plan

PPO and Non-PPO Providers: Plan Participants may obtain health care services from In-Network providers or Out-of-Network providers. Because providers are added to and removed from networks during the year you should call Anthem Blue Cross or ask your Provider to verify its contracted network status **before you visit** that provider to assure you will be able to receive In-Network (PPO) benefits for the services you need.

- **PPO Providers:** In-Network Providers, referred to as "PPO Providers" have agreements with Anthem Blue Cross of California (BlueCard outside of California), HMC (for mental health and substance use disorder services) or Podiatry Plan, Inc. (for podiatry services) under which they provide health care services and supplies for a favorable negotiated fee for Plan Participants. When a Plan Participant uses the services of a PPO Provider, the Plan Participant is responsible for paying the applicable coinsurance on the negotiated fee for any covered services or supplies, subject to the Plan's deductibles, limitations and exclusions. Generally, you will not be balance billed if you use PPO Providers because the Allowed Amount is the contractually negotiated fee. (Note, however, that most hip and knee replacement surgeries performed in a Hospital are not subject to this rule, and you will want to use a Designated Hospital to assure that you are not Balance Billed. Please read the following page if you are planning to get a hip or knee replacement surgery).

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

- **Non-PPO Providers:** Out-of-Network Providers, referred to as "Non-PPO Providers" have no agreements with Anthem Blue Cross, HMC or Podiatry Plan, Inc. and are generally free to set their own charges for the services or supplies they provide. For covered services and supplies from Non-PPO Providers, the Fund generally pays 50% of the Allowed Amount, subject to the Fund's deductibles, limitations and exclusions. **Caution: Because Non-PPO Providers often charge more than the Fund's Allowed Amount, Non-PPO Providers may bill you for any charges in excess of the Allowed Amount. This is called Balance Billing. Thus, when you use Non-PPO Providers, you are generally responsible for your 50% coinsurance plus all charges above the Allowed Amount (Balance Billing). *You can avoid Balance Billing and higher out-of-pocket expenses by using PPO Providers.***

Directories of PPO Providers

A directory of PPO Health Care Providers is available from Anthem Blue Cross, HMC and Podiatry Plan, Inc. There is no cost to you for access to the provider directory. **Remember, because Providers are added to and dropped from the PPO networks throughout the year it is best if you ask your Provider if they are still in the network or contact Anthem Blue Cross, HMC or Podiatry Plan, Inc. *before* you receive services.**

- **Anthem Blue Cross PPO Network**
  www.anthem.com/ca
  Find a PPO Provider inside California: 855-686-5613
  Find a PPO Provider outside California: 800-810-2583
- **HMC HealthWorks (HMC)**
  hmc.personaladvantage.com
  Company user name: SCUFCW
  800-461-9179
- **Podiatry Plan, Inc.**
  www.podiatryplan.com
  800-367-7762 or 415-928-7762

Out-of-Area Benefits

Out-of-Area benefits are provided in situations where there is no PPO Provider available to provide a Medically Necessary service or supply within 40 miles of the Participant's home, and the Participant uses a Non-PPO Provider for the service or supply. When that happens, the Participant is eligible for Out-of-Area benefits, and the Plan will pay benefits at the applicable in-network percentage (75% or 80%) of the Allowed Amount. The Participant will be responsible for his or her in-network coinsurance (20% or 25%) and for any charges that exceed the Allowed Amount.

Designated Hospitals for Certain Hip & Knee Replacement Surgeries

The Fund's Allowed Amount for Hospital charges incurred in the state of California for a routine hip and/or knee joint replacement surgery is $30,000. Any charge over the Allowed Amount will be your responsibility. This benefit design applies ***only*** to routine total hip or knee replacements **in the state of California.** Amounts denied as over the Allowed Amount for a procedure will not accumulate toward your Out-of-Pocket Maximum.

Designated Hospitals

For hip and knee replacements, certain Hospitals in California that will hold costs under the Allowed Amount are "Designated Hospitals." If you use a Designated Hospital, you will not be Balance Billed. For surgeries done outside the state of California normal surgery benefits will apply. Please note, not all PPO Hospitals are Designated Hospitals. You can access a list of Designated Hospitals on the Fund's website or by calling HMC at 844-751-4530.

How Can I Make Sure My Costs are Under the Allowed Amount?

Clearly, it makes sense to have your procedure done at a Designated Hospital. You'll receive quality care at an affordable price for you and the Fund. To make sure you keep costs under the Allowed Amount (or at a price you can afford if you decide not to go to a Designated Hospital for your care), precertify your care through Anthem Blue Cross at the telephone number listed on the Quick Reference Chart.

Contact HMC Healthworks or the Fund Office if you have questions or need help. To receive the highest level of benefits, have the service preauthorized by Anthem Blue Cross and plan to have your procedure at a Designated Hospital.

What if I don't live near a Designated Hospital?

We have a "safety net" for participants who need to travel to a Designated Hospital. If you *qualify* for out-of-area benefits, hospital charges will be covered as they are for any other hospitalization. The $30,000 Allowed Amount will not apply.

Exceptions Process

If you go to a Hospital that has not agreed to accept the Fund's Allowed Amount, the Fund may provide benefits in accordance with normal hospitalization benefits in the following situations:

- You do not have access to a Designated Hospital or the service cannot be obtained within a reasonable wait time or travel distance; and
- The procedure is not a routine hip or knee replacement surgery (e.g., if comorbidities exist).

Information About Hip & Knee Replacements at Designated Hospitals

Upon request, HMC Healthworks will provide you with:

- A list of Designated Hospitals that keep their charges within the $30,000 Allowed Amount;
- A list of Hospitals that will accept a negotiated price above the Allowed Amount; and

Utilization Management (UM) — Indemnity PPO Plan

Purpose of the Utilization Management (UM) Program

The Plan is designed to provide you and your eligible Dependents with financial protection from significant health care expenses. The development of new medical technology and procedures and the ever-increasing cost of providing health care makes it important to manage the costs of maintaining your Plan.

To enable the Plan to provide coverage in a cost-effective way, a Utilization Management Program has been adopted to help control increasing health care costs by avoiding unnecessary services or services that are more costly than others that can achieve the same result. By doing this, the Fund is better able to afford to maintain the Plan and all its benefits. If you and your Dependents follow the procedures of the Fund's UM Program, you may avoid some out-of-pocket costs. If you don't follow these procedures, you may pay more out of your own pocket.

Elements of the Utilization Management Program

The Plan's UM Program consists of:

1. **Precertification (preservice) review:** Review of proposed health care services **before** the services are provided;
2. **Concurrent (continued stay) review:** Ongoing assessment of the health care as it is being provided, typically involving inpatient confinement in a Hospital or health care facility or review of the continued duration of healthcare services;
3. **Retrospective review:** Review of health care services **after** they have been provided; and
4. **Case management:** In some instances, a patient's needs are met better by alternative care outside a Hospital setting. Alternative care may include home health care, Skilled Nursing Facility care, outpatient rehabilitation and other medical approaches and settings.

Precertification Review

How Precertification Review Works: Precertification is a procedure 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 is Medically Necessary. **The following services must be Precertified *before* the services are provided.**

Services That Must be Precertified

The following Services must be precertifed by Anthem Blue Cross. Call 800-274-7767 to obtain certification.

1. All **elective inpatient admissions** for medical or surgical care, including hospitalizations. (Note: For pregnant women, Precertification is required only for Hospital stays that last or are expected to last longer than 48 hours for a vaginal delivery and 96 hours for a C-section). If you use a PPO Hospital, your PPO Hospital or PPO Physician will automatically obtain the Precertification review for you, and the Anthem Blue Cross PPO will issue you a letter with their approval or denial. If you use a Non-PPO provider, you or your provider ***must*** call Anthem Blue Cross PPO for Precertification.
2. **Transplants** should be Precertified as soon as the Participant is identified as a potential transplant candidate.
3. Inpatient rehabilitation admission (for medical reasons);
4. All **Hospice**; and
5. All **Skilled Nursing Facility** admissions.

HMC Healthworks (HMC) precertifies the following services (Participants call: 800-461-9179, Providers call: 855-487-8914):

All elective inpatient admissions, residential treatment (including detoxification), intensive outpatient treatment, and partial day hospitalization/partial day care for Behavioral Health care (mental health or chemical dependency) must be precertified by HMC.

In addition, you are strongly encouraged to contact HMC prior to receiving outpatient treatment for mental health or Chemical Dependency, so that you may be directed to a qualified HMC Provider (in network).

Podiatry Plan, Inc. precertifies the following services (Call: 800-367-7762 or 415-928-7762):

Benefits for ***all*** podiatry surgery. You must use Podiatry Plan, Inc. Providers or the Fund does not pay benefits.

Precertification 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, and any benefit limitations that may apply.

Penalty for Failure to Precertify			
Service	**PPO**	**Out-of-Area**	**Non-PPO**
Inpatient Hospital and rehabilitation facility services (medical), except with respect to Emergency Care.	Precertification is automatic when an Anthem PPO Provider is used.	Precertification with Anthem is required. There is a 20% benefit reduction for non-compliance. The penalty cannot be reimbursed from HRA funds.	
Skilled nursing facility	Precertification is automatic when an Anthem PPO Provider is used.	Precertification with Anthem is required. There is a 20% benefit reduction for non-compliance. The penalty cannot be reimbursed from HRA funds.	
Hospice care	Precertification is automatic when an Anthem PPO Provider is used.	Precertification with Anthem is required. There is a 20% benefit reduction for non-compliance. The penalty cannot be reimbursed from HRA funds.	
Inpatient mental health or substance abuse treatment and rehabilitation facility services, except with respect to Emergency Care.	Precertification is automatic when HMC coordinates the admission. If HMC does not coordinate, Precertification is required.	Precertification with HMC is required. There is a 20% benefit reduction for non-compliance. The penalty cannot be reimbursed from HRA funds.	
All podiatry surgery	All podiatry surgery must be authorized by Podiatry Plan of California (Podiatry Plan, Inc.) and rendered by Podiatry Plan, Inc. Providers (or Out-of-Area Providers, if applicable) or there is no coverage available.		Not covered (cannot be reimbursed from HRA funds)

How to Request Precertification

You or your Physician must call the appropriate UM company (Anthem Blue Cross, HMC or Podiatry Plan, Inc.) at the telephone number shown in the Quick Reference Chart in the front of this SPD.

1. The caller should be prepared to provide all of the following information: the Fund's name, Employee's name, patient's name, address, phone number and Social Security number (or Member ID number); Physician's name and phone number or address; the name of any Hospital or 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.
2. If the caller doesn't properly follow the Precertification review process, the caller will be notified as soon as possible but not later than five calendar days after the request.
3. If additional information is needed, the UM company will advise the caller. The UM company will review the information provided, and will let the Participant, the Physician or Hospital, and the Fund Office know whether or not the proposed health care services have been certified as Medically Necessary. The UM company will usually respond to the patient's treating Physician **by telephone within three working days (but not later than 15 calendar days) after it receives the request and any required medical records and/or information**, and its determination will then be confirmed in writing.
4. If a Participant's admission or service is determined not to be Medically Necessary, the Participant and his or her Physician will be given recommendations for alternative treatment. The Participant may also pursue an appeal.

Restrictions and Limitations of the Utilization Management Program

1. The fact that your Physician recommends surgery or hospitalization or that your Physician 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 an Eligible Medical Expense or Medically Necessary service.
2. The UM Program does not diagnose or treat medical conditions, validate eligibility for coverage, or guarantee payment of Plan benefits. The UM company's 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 document. **For example, benefits would not be payable if your eligibility for coverage ended before the services were rendered or if the services were not covered by the Plan.**
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 the UM company does not precertify proposed surgery/treatment/service or admission. However, the benefits payable, if any, by the Plan may be affected by the determination of the UM company and Plan terms.
4. Precertification of a service does not guarantee that the Fund will pay benefits for that service. Other factors (such as ineligibility for coverage on the actual date of service and other Plan terms) may affect whether benefits are payable.

How Concurrent (Continued Stay) Review Works

1. When you are receiving medical services in a Hospital or other inpatient health care facility, Anthem Blue Cross or HMC will monitor your stay by contacting your Physician to assure that continued hospitalization is Medically Necessary, and to help coordinate your medical care with benefits available under the Plan.
2. If your continued stay or services are found ***not*** to be 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), the patient and his or her Physician will be notified. This does not mean that the patient must leave the Hospital or stop receiving services, but if the patient chooses to stay or continue services, all expenses incurred after the notification will be the Patient's responsibility.

Emergency Hospitalization: If you or a Dependent requires emergency hospitalization due to an Emergency Medical Condition, there may be no time to contact Anthem Blue Cross or HMC (if the emergency admission is for behavioral health or substance abuse treatment) before the admission. If this happens, Anthem Blue Cross or HMC must be notified of the Hospital admission within 48 hours of admission (you, your Dependent, the Physician, the Hospital, a family member or friend can make that phone call). This will enable Anthem Blue Cross or HMC to assist you with discharge plans, determine the need for continued medical services, and/or advise the patient's Physician of the various PPO Providers and benefits available and offer recommendations, options and alternatives for continued medical care.

Pregnancies: Pregnant women should notify Anthem Blue Cross as soon as possible once they know they are pregnant. This helps to assure that the pregnant woman will receive adequate prenatal care and allow for planning for the upcoming delivery. It also enables Anthem Blue Cross to work with the treating Physician to monitor for high risk pregnancy factors and to assist the pregnant woman in completing the steps to assure that Plan benefits will be available for the newborn Child. You must contact the Fund Office if you wish to enroll your newborn in the Plan. Please remember that pregnancy and maternity for a Child is not covered by the Plan (except for preventive services required under the ACA).

Retrospective Review

If you don't follow the Precertification 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 UM company perform a **retrospective review** to determine if the services performed or received were Medically Necessary.

1. If the UM company determines that the services were **not Medically Necessary, no Plan benefits will be payable for those services**.
2. If the UM company determines that the services **were Medically Necessary**, benefits will be payable subject to Plan terms, limitations and exclusions.

Some services are not subject to retrospective review and will not be covered unless they are precertified.

Appealing a UM Determination (Appeals Process)

You may request an appeal of any adverse decision made during the Precertification, concurrent review, retrospective review or case management process described in this chapter.

Disease Management (DM) — Indemnity PPO Plan

THIS CHAPTER APPLIES ONLY TO EMPLOYEES AND SPOUSES OR DOMESTIC PARTNERS WHO ARE ELIGIBLE FOR AND ENROLLED IN THE INDEMNITY PPO MEDICAL PLAN.

The Disease Management (DM) Program is a valuable Indemnity PPO Medical Plan program for Participants and their enrolled Spouses/Domestic Partners who are diagnosed with **heart disease and related conditions, asthma or diabetes**. It is designed to help prevent or minimize the effects of these conditions.

If the program's administrator, HMC HealthWorks® (HMC), identifies you or your Spouse/Domestic Partner as moderate to high risk for one of these conditions, the Fund will contact you by mail. Then, HMC will call you to discuss your eligibility and give you more details on how the DM Program works. If you're then invited to participate, you may enroll in the program, and you will be entitled to lower Prescription Drug copays and additional contributions to your Health Reimbursement Account (lowering your out-of-pocket expenses) as follows:

Disease Management Program Incentives

Zero or Reduced Prescription Drug Copays for Condition — Specific Maintenance Drugs	Extra Health Reimbursement Account (HRA) Contributions
Copays while you actively participate in the program and for a year after you graduate: **30-day supply:** • Formulary generic: $0 copay • Formulary brand name: $4 copay • Non-formulary: $25 copay **90-day supply:** • Formulary generic $0 copay • Formulary brand name: $8 copay • Non-formulary: $50 copay	Up to $300 in extra contributions to your HRA, which is used to pay your covered out-of-pocket medical and prescription drug expenses: • $40 in month one; • $40 in month two; • $60 in month three; • $60 in month four; and • $100 after program graduation. See chapter beginning on page 20 for information on how your HRA works.

If you are notified that you are eligible for this program, but you choose not to enroll, you will be assessed a $500 penalty, which will likely increase your out-of-pocket expenses. You will receive a written notice from the Fund Office before this change goes into effect. This penalty will apply annually until you complete the program. It will be removed following notification from HMC Health Works that you have enrolled in the program. If you do not complete the program, the $500 penalty will be reapplied and will continue into the next and subsequent years. It will only be removed in the year following the year in which you decide to participate in the program.

Who Can Participate?

HMC reviews the Benefit Fund's medical and Prescription Drug claims to identify individuals with asthma, heart disease and related conditions or diabetes who might benefit from the DM Program. The DM Program is available only to Employees and their enrolled Spouse or Domestic Partner who are invited to participate by HMC. Enrollment in the program is voluntary and confidential.

ONCE INVITED, those who choose to enroll in the program will work directly with a team of professionals and participate in one-on-one clinician calls. They will also receive health education materials and tools they can use at home and share with their doctors.

Participation in the DM Program is voluntary. However, if you or your Spouse/Domestic Partner choose not to participate in the DM Program within 45 days after we send you a letter requesting that you participate, you will be subject to a $500 penalty. HRA funds cannot be used to reimburse this penalty for failure to participate.

This $500 penalty will remain in place until you decide to participate in the program. It will be removed following notification from HMC that you have enrolled in the program. If you do not complete the program, the $500 penalty will be reapplied and will continue into the next and subsequent years. It will only be removed in the year following the year in which you complete the program.

Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), the Fund must provide an alternative for any Participant who has a health condition that makes it unreasonably difficult (or medically inadvisable) to attempt to meet a standard in a wellness program.

If you think you might be unable to meet a program standard for a reward (or to avoid the penalty) under the DM Program, due to your health status or disability, contact the Fund Office to discuss how you might qualify for an opportunity to earn the same reward (or to avoid the penalty) by different means.

Contact the Fund Office and we will work with you and, if you wish, your doctor, to find a DM Program standard with the same reward that is right for you in light of your health status.

Excluded Services and Limitations

The Benefit Fund does not pay benefits for the following:

- Services or supplies that are not Medically Necessary unless specifically covered under the Plan, such as preventive care benefits.
- Experimental or investigative services, supplies, procedures, treatments or drugs, except as required under the federal Affordable Care Act for clinical trials.
- Expenses directly related to a non-covered procedure, service, treatment, supply or drug.
- Services provided by an immediate relative of an eligible Participant or by a member of a Participant's household, except for Eligible Medical 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.)
- Conditions covered by Workers' Compensation or arising out of or in the course of any employment or self-employment.
- Injuries resulting from any form of warfare or invasion or while on active duty with the armed forces.
- Charges incurred while the patient's coverage is not in effect (i.e., while the patient is not eligible for coverage).
- Services or supplies for which there is no charge or liability to pay.
- Services or supplies furnished by or for the United States government or any other government, unless payment is legally required.
- Any portion of expenses provided under any governmental program or law under which the individual is or could be covered.
- Any service or supply furnished by a Hospital or facility run by the federal government or other authorized agency, or at the expense of such agency or facility, except as otherwise required by federal law.
- Charges in excess of covered charges (for example, charges that exceed Allowed Amounts as determined by the Fund).
- Claims submitted more than one year after the date a covered charge is incurred.
- 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 provisions relating to Third Party Liability on page 92.
- **Educational Services**. Even if they result from an Injury, Illness or disability of a covered individual, the following expenses are not payable by the Plan: 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, listening systems, device/programs/services for behavioral training including intensive intervention programs for behavior change and/or developmental delays or auditory perception or listening/learning skills, programs/services to remedy or enhance concentration, memory, motivation, reading or self-esteem, etc., special education and associated costs in conjunction with tactile systems like Braille or sign language education for a patient or family members, and implantable medical identification/tracking devices.

In addition to the above general exclusions and limitations, the Indemnity PPO Medical Plan does not pay for:

- Services or supplies not prescribed, recommended or approved by a Physician or Healthcare Practitioner.
- Services or supplies that are not Medically Necessary for the treatment of an Illness or Injury, unless specifically covered under the Plan, such as covered preventive care services and sterilization procedures.
- Treatment of infertility, except for the initial exam and diagnostic services.
- Services to reverse voluntary surgically induced infertility.
- Personal items provided in a Hospital.
- Cosmetic procedures (except surgery to repair damage caused by accidental bodily Injury, breast reconstruction following a mastectomy, or restorative surgery performed during or following mutilative surgery required as a result of Illness or Injury).

- Expenses incurred by an organ donor, unless the recipient of the organ is a Participant in the Indemnity PPO Medical Plan.
- Expenses incurred at an out-of-network Hospital (i.e., a Non-PPO Hospital) by an organ donor, unless the donor and the recipient are both Participants in the Indemnity PPO Medical Plan.
- Custodial care and homemaker services.
- Vocational training.
- Ambulance services for transportation primarily to suit the patient's or Physician's convenience.
- Paramedic services when the patient is not transported to a Hospital.
- Podiatric treatment by a Podiatrist or other Healthcare Practitioner who is not affiliated with the Podiatry Plan, Inc.
- Treatment of mental health disorders or substance abuse, other than Emergency Services received in an emergency room (these may be covered under the EMAP).
- Treatment on or to teeth or gums, including tumors (these may be covered under the Dental Program).
- Pregnancy and maternity care for a Dependent Child (except for preventive care services covered under the Preventive Care Guidelines).
- Tobacco cessation programs (except as covered under the Preventive Care Guidelines).
- Weight loss programs (except as covered under the Preventive Care Guidelines).
- Physical fitness programs or club memberships.
- Surrogate pregnancies and all related charges, both when the surrogacy is for a Plan Participant and when a Plan Participant is the surrogate.

In addition to the general exclusions and limitations listed to the left, Prescription Drug exclusions are shown on page 45.

In addition to the general exclusions and limitations listed to the left, the EMAP does not pay for:

- Services otherwise provided under the Indemnity PPO Medical Plan.
- Court-ordered services, except those that HMC would have deemed Medically Necessary and appropriate, were the court not involved.
- Services or treatment not provided under the EMAP program.

Kaiser HMO or Anthem HMO (Platinum Plus Only)

Platinum Plus participants are offered the opportunity to enroll in one of the Fund's HMO medical plans, as an alternative to the Indemnity PPO Medical Plan. HMO enrollees are not eligible for HRA Funds.

Participants in the Gold, Silver and Platinum Plans do not have an HMO option available.

The two HMO medical plans available to Platinum Plus Participants who live in the HMO's service areas are:

- The Kaiser Permanente HMO; or
- The Anthem™ Blue Cross HMO Medical Plan.

When you enroll in an HMO, 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 Fund's Prescription Drug Program using OptumRx Participating Pharmacies (see page 39).
- **Mental Health/Substance Abuse Benefits** — if you are in Kaiser, mental health and substance abuse services/ treatment is provided through Kaiser. If you are in the Anthem HMO, these benefits are provided through the EMAP administered by HMC.
- **Acupuncture and Chiropractic/Spinal Manipulation** — provided through the Fund subject to a Schedule of Allowances and annual dollar maximum of $1,000 per person.
- **Injectables** — certain injectables not covered by your HMO will be covered by the Fund at 80%.
- **Vision Care:**
  - **Ages 0-18** — Plan pays up to $150 per Child per calendar year. HMO provides essential pediatric services up to age 18.
  - **Ages 19 and up** — Plan pays up to $150 per person per calendar year for exam and materials.

Vision benefits are automatically included with medical coverage at ***no additional cost to you***. You may opt-out by calling the Fund Office and completing the proper form. Dropping your vision coverage ***will not reduce your weekly payroll deductions***.

Payment for prescription lenses will be made only if no more than 12 months have elapsed between the date of the last vision examination and the date glasses or contact lenses are ordered, except when a lens change is required following eye surgery or other conditions.

When you enroll in an HMO, you must use the HMO's Providers for all of your medical care. Benefits outside the HMO network are limited to Emergency Services, and claims for Emergency Services must be submitted to the HMO.

Summary of HMO Benefits

Your HMO's Evidence of Coverage (EOC) explains fully the benefits it provides. On the next page is a brief summary of the benefits provided by each HMO plan. If there is a conflict between any description of HMO benefits in this booklet and the HMO's official EOC or the Fund's contract with the HMO, the EOC or the contract with the HMO will control. Please call the HMO at the telephone number listed on the Quick Reference Chart for a copy of the EOC.

If you are covered under the Fund's Kaiser HMO Plan or Anthem Blue Cross HMO Plan, your medical benefits are summarized in the following chart. Your Prescription Drug benefits are provided by OptumRx and are outlined beginning on page 39.

Health Mainenance Organizations (HMOs)		
Plan Features & Benefits	**Kaiser Permanente HMO**	**Anthem™ Blue Cross HMO**
Choice of Provider	You must receive all care from Kaiser providers and facilities. Unless noted otherwise below, care received from non-Kaiser Providers is not covered except for Emergency Services.	You must choose between the Select HMO network and the Blue Cross HMO (CACare) Network, and each enrolled family member must have a primary care physician (PCP) in the same network. Unless noted otherwise below, care received outside your chosen network is not covered except for Emergency Services.
Lifetime Maximum Benefit	None	None
Annual Maximum Benefit	None	None
Covered Charges	Only services received from HMO providers are covered except for Emergency Services.	
Annual Deductible	None	None

Health Mainenance Organizations (HMOs)				
Plan Features & Benefits	**Kaiser Permanente HMO**	**Anthem™ Blue Cross HMO**		
Annual Medical Out-of-Pocket Maximum	$1,500/person $3,000/family	$1,500/person $4,500/family		
Copays	**Kaiser Permanente HMO**	**Anthem Select HMO Network**	**Anthem HMO (CACare) Network**	**If you Live Outside the Select HMO Network Service Area**
Primary Care Physician (PCP) Office Visit (or an urgent care visit within your PCP's medical group)	$25 per visit	$25 per visit	$35 per visit	$25 per visit
Specialist/Non-Physician Office Visit	$35 per visit	$35 per visit	$45 per visit	$35 per visit
Urgent Care (outside your PCPs medical group)	$25 per visit	$50 per visit	$75 per visit	$50 per visit
Emergency Room Visit (copay waived if admitted)	$100 per visit	$100 per visit	$150 per visit	$100 per visit
Outpatient Surgery	$150/procedure	$150/procedure	$200/procedure	$150/ procedure
Hospital Services	$500/admission	$500/admission	$750/admission	$500/admission
Other Services	Family planning, preventive care, podiatric care, medical equipment and supplies, and hearing aids are provided through the HMO.			
Acupuncture and Chiropractic/Spinal Manipulation	Provided through the Fund. Fund pays 100% of Allowed Amount after $25 copay for office visits, or 80% of Allowed Amount for x-ray/lab. Only those services listed in the Schedule of Allowances are covered. You are responsible for charges above the Allowed Amount. $1,000 per person annual maximum combined for all services.			
Injectables (except insulin)	Provided through the Kaiser HMO. If not covered by Kaiser HMO, paid by the Fund at 80% of Allowed Amount. After Ancillary Benefits Out-of-Pocket Maximum is met, covered injectables are paid by the Fund at 100% of Allowed Amount.	Provided through Anthem Blue Cross HMO. If not covered by the Anthem Blue Cross HMO, paid by the Fund at 80% of Allowed Amount. After the Annual Medical Out-of-Pocket Maximum is met, covered injectables are paid at 100% of Allowed Amount.		
Ancillary Benefits Out-of-Pocket Maximum	There is an Ancillary Benefits Out-of-Pocket Maximum of $2,500 per Participant per Calendar Year. This out-of-pocket maximum includes the portion of the Allowed Amount you pay for covered Injectables, plus the copays or portion of Allowed Amounts that you pay for Acupuncture or Chiropractic Care/ Spinal Manipulation. After this out-of-pocket maximum is met, covered Ancillary Benefits are paid at 100% of Allowed Amount for the remainder of the Calendar Year.	The Anthem Blue Cross HMO does not have a separate Ancillary Benefits Out-of-Pocket Maximum. The copay or the portion of the Allowed Amount that you pay for all ancillary benefits, such as Injectables, Acupuncture and Chiropractic Care/Spinal Manipulation, accumulates to the Annual Medical Out-of-Pocket Maximum listed above. After the Annual Medical Out-of-Pocket Maximum is met, covered services are paid at 100% of Allowed Amount for the remainder of the calendar year.		

Mental/Behavioral Health and Substance Abuse				
Plan Features & Benefits	**Kaiser Permanente HMO**	**Anthem™ Blue Cross HMO**		
Choice of Provider	Only services received from Kaiser Permanente providers are covered except for Emergency Services.	Provided through EMAP administered by HMC. Only services received from HMC providers are covered except for Emergency Services.		
Copays	**Kaiser Permanente HMO**	**Anthem Select HMO Network**	**Anthem HMO (CACare) Network**	**Outside Select Area**
Hospital/Rehab Facility Services	$500 per admission	$500 per admission		
Office Visits				
Per individual visit with a counselor or Ph.D. (e.g., psychologist)	$25	$25	$25	$25
Per individual visit with M.D. (e.g., psychiatrist)	$25	$25	$35	$25
Per group session	$12	$12.50	$12.50	$12.50
Emergency Room Visit	$100 per visit (waived if admitted)	$100 per visit (waived if admitted)		

Patient Protections

Kaiser Permanente 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. Most personal plan physicians are primary care physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as primary care physicians). Some specialists who are not designated as primary care physicians but who also provide primary care may be available as personal plan physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as primary care physicians may be available as personal plan physicians.

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. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. Please see your Evidence of Coverage for more information.

Anthem Blue Cross HMO Enrollees

The Anthem™ Blue Cross HMO 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 Select HMO Network or the Blue Cross HMO Network) and who is available to accept you or your family members. Until you make this designation, the Anthem Blue Cross HMO designates one for you.

For information on how to select a primary care provider and for a list of the participating primary care providers in the Select HMO Network or the Blue Cross HMO Network, contact Anthem Blue Cross at 800-227-3771. To find a PCP in the Select HMO network, you may also visit **http://tinyurl.com/SelectHMOSearch**. To find a PCP in the Blue Cross HMO Network, visit **http://tinyurl.com/BlueCrossHMOSearch**. For Children, you may designate a pediatrician as the primary care provider.

You do not need prior authorization from Anthem 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 in your network who specializes in obstetrics or gynecology. The health care professional, however, may be required to comply with certain procedures, including obtaining prior authorization for certain services, following a pre-approved treatment plan, or procedures for making referrals. For a list of participating health care professionals who specialize in obstetrics or gynecology, contact your medical group or the Anthem™ Blue Cross HMO at 800-227-3771. Please see your Evidence of Coverage for more information.

Dental and Orthodontic Coverage

You have a choice between the Indemnity Dental Plan and one of the Prepaid Dental Plans offered by the Fund. Please refer to the separate document titled *Dental Program for Active Participants in All Plans and All Retirees* for a complete description of the dental benefits offered under the Fund. Contact the Fund Office if you do not have a copy of this Dental Program document. For your convenience, we have included a brief summary of each of the dental and orthodontic options available. **If there are any discrepancies between this document and the *Dental Program for Active Participants in All Plans and All Retirees,* the Dental Program document will prevail.**

Once you choose a dental plan, you must remain in that dental plan until the next annual Open Enrollment. See page 12 for more information. Whether you choose the Indemnity Dental Plan or a Prepaid Dental Plan, your eligible Dependents must be enrolled in the same dental plan you enroll in.

If you have a Child who is eligible for coverage but who lives outside the Prepaid Dental Plan Service Area, you need to contact the Fund Office if you want the entire family moved to the Indemnity Dental Plan.

Dental/Orthodontic Opt-Out Choice

The Fund's Dental and Orthodontic benefits are automatically included with your medical coverage. However, you may opt out of (i.e., drop) Dental/Orthodontic coverage during Open Enrollment. There is no financial advantage to you for dropping Dental/Orthodontic coverage. If you do, your payroll deductions will not go down. You will pay the same amount for health care benefits with or without Dental/Orthodontic coverage. What's more, your covered family members (if any) will also lose the coverage you drop. If you want to opt out of Dental/Orthodontic coverage, call the Fund Office for more information.

Prepaid Dental Plans

The Prepaid Dental Plans include specific dental clinics. If you choose a Prepaid Dental Plan, you must live in the area served by that Dental Plan (i.e., the Service Area), and you and your Dependents can receive dental care only at that specific clinic and only from that location. Following is the list of the Prepaid Dental Plans available:

Prepaid Dental Plans		
Dentist	**Address**	**Phone**
Dr. Schnierow and Associates	13450 South Hawthorne Boulevard, Hawthorne, CA 90250	310-679-0106
Ilya Zak, D.D.S.	3620 Long Beach Boulevard Suite B-6, Long Beach, CA 90807	562-426-6458
Allcare Dental	1200 North Tustin Avenue, Suite 200, Santa Ana, CA 92705	855-866-2273
San Diego Dental Group	7557 El Cajon Boulevard, Suite C, La Mesa, CA 91942	619-464-4242
Santa Monica Dental Practice	1244 7th Street, Suite 101, Santa Monica, CA 90401	310-393-0743

Dental Service	Prepaid Dental Plans			
	Silver	**Gold**	**Platinum**	**Platinum Plus**
Annual Deductible	None			
Annual Benefit Maximum • Ages 0-18 years • Ages 19 and up	 None None			
Limitations	Only services listed in the Dental Schedule of Allowances are covered. The schedule is available at **scufcwfunds.com** and from the Fund Office.			
Benefits **The Participant is responsible for the full cost of services not on the Dental Schedule of Allowances which is published annually.**	Most services are covered in full. For major dental treatment, you pay the following copays: **Crown/pontics:** $75 copay **Prosthodontics:** $100 copay **Endontics:** $45 anterior, $90 bicuspid, $125 molar			

Indemnity Dental Plan

If you choose coverage under the Indemnity Dental Plan, you may use any dentist of your choice. You must satisfy the dental deductible each year, after which the Indemnity Dental Plan will pay a percentage of the Covered Charges for services performed by your dentist or hygienist. The following chart summarizes the key features of the Indemnity Dental Plan.

Dental Service	Indemnity Dental Plans			
	Silver	Gold	Platinum	Platinum Plus
Annual Deductible (waived for preventive and diagnostic)	$50/person $150/family	$50/person $150/family	$50/person $150/family	$50/person $150/family
Annual Benefit Maximum • Ages 0-18 years • Ages 19 and up	 None $1,000/person	 None $1,800/person	 None $1,800/person	 None $1,800/person
Limitations	Only services listed in the Dental Schedule of Allowances are covered. The schedule is available at **scufcwfunds.com** and from the Fund Office.			
Plan Payment	**Preventive/Diagnostic:** 100% of Allowed Amount **Basic Restorative:** 80% of Allowed Amount **Major Restorative:** 70% of Allowed Amount (The Allowed Amount is the lesser of the dentist's billed charge or the amount shown in the Dental Schedule of Allowances which is published annually).			

Orthodontic Benefits

For orthodontia, you can use any orthodontist you choose, but your out-of-pocket costs will likely be substantially lower if you use a Network Panel Orthodontist. Network Panel Orthodontists have contracted with the Fund to limit their prices for orthodontia services.

If you use an orthodontist who is not on the Network Panel, you pay coinsurance plus all costs that exceed the Plan's benefit maximum. The first chart below shows the Plan's payment and your cost sharing responsibility if you use a Network Panel Orthodontist. The second chart below shows your coinsurance for non-panel orthodontists and the Plan's benefit maximums.

Prior to receiving any orthodontic treatment, you need to have your treatment plan approved by the Fund's Orthodontic consultant. Please have the following form filled out and submitted to the Fund for review: **scufcwfunds.com/wp-content/uploads/2018/05/Request-for-Authorization-and-Benefits-for-Orthodontic-Treatment.pdf**.

Orthodontic	Network Panel Orthodontist			
	Silver	Gold	Platinum	Platinum Plus
Plan Payment	100% of negotiated rate up to the Lifetime Benefit Maximum			
Lifetime Benefit Maximum	$1,000/person	$1,800/person	$1,800/person	$1,800/person
Participant Responsibility*	Up to $1,700/person based on the services provided	Up to $900/person based on the services provided	Up to $900/person based on the services provided	Up to $900/person based on the services provided

** Patients who obtain care through a network panel orthodontist are also responsible for the following expenses: The cost of special diagnostic records in excess of the Plan's Allowed Amount, lost or broken appliance(s), fee for missed appointments or cancellations made without 24-hour notice, cost of treatment obtained elsewhere should a patient not cooperate with the panel orthodontist and cost of treatment that extends past 30 months due to the patient's failure to cooperate with the panel orthodontist. In addition, when treatment is provided in two phases for Children whose permanent teeth have not all appeared, there may be an additional charge for Phase II treatment that causes the total fee for both Phase I and II Treatment to exceed the Maximum Allowed Amount of $2,700 per Participant. If that happens, you are responsible for the additional expense.*

Call the Fund Office to locate a network panel orthodontist near you.

Orthodontic	Orthodontist Not On Panel			
	Silver	Gold	Platinum	Platinum Plus
Plan Payment	70%	75%	75%	75%
Lifetime Benefit Maximum	$1,000/person	$1,800/person	$1,800/person	$1,800/person
Participant Responsibility	Balance of Provider's fee for service after Plan payment			

Death and Accidental Death & Dismemberment Benefit

The Fund provides you with the Death and Accidental Death & Dismemberment benefits described in this Chapter. In order to qualify for these benefits, you must:

- Be enrolled in one of the Fund's medical plans; and
- Be eligible for coverage based on hours you worked in Covered Employment; and
- Have made your timely contributions toward the cost of your Employee coverage at the time of your death or accidental Injury.

Beneficiary

If you die while covered by these benefits (meaning while an active Employee covered by this Plan), the Death Benefit will be paid to the beneficiary you name. You may name anyone you wish as beneficiary and may change your beneficiary at any time without the consent of the beneficiary. Your initial beneficiary designation and any beneficiary changes you make afterward take effect on the date the Fund Office receives your Beneficiary Designation form, if it is received in the Fund Office before your death.

A beneficiary must be one or more natural persons or a trustee of a legally established trust for the benefit of one or more natural persons. You may download a Beneficiary Designation form from the Fund's website at **scufcwfunds.com** or get one from your Union Local or the Fund Office. Remember to complete the designation of your beneficiary, you must submit your completed beneficiary designation form to the Fund Office.

If no beneficiary is named or surviving upon your death, the Death Benefit will be paid to the first individual(s) listed below who is living at the time of your death:

- Your Spouse; if none, then
- Your Children, share and share alike; if none, then
- Your parents, including adoptive parents, share and share alike; if none, then
- Your siblings, share and share alike.

If there are no such individuals living at the time of your death then, in lieu of the Active Employee Death Benefit, the Plan will pay only the burial expense payment described below, and the Accidental Death & Dismemberment benefit will not be payable.

Death Benefits Payable

The Fund provides Covered Employees with the following death benefits:

- **Active Employee Death Benefit.** Upon your death (i.e., the death of the covered Employee), a benefit will be payable to your beneficiary. The value is based on your Years of Service, as shown in the chart on the next page.

  If you have no eligible beneficiary at the time of your death, the Fund will pay a burial expense benefit in lieu of the Employee Death Benefit to the person who presents evidence of having paid your burial expenses. The burial expense benefit will not exceed the Fund's maximum for burial expenses.

  Eligible burial expenses include: Expenses of the funeral home, embalming or other preparation for burial, transportation to the gravesite, purchase of the gravesite, burial costs, burial service flowers and the cost of religious services. Pre-need burial costs paid for by the Eligible Employee are not Eligible Burial Expenses. The burial expense benefit is not payable if there is a death benefit payable to your beneficiary.
- **Dependent Death Benefit:** This is a benefit payable to covered Employees upon the death of their lawful Spouse; enrolled unmarried Child/stepchild up to age 19, or between 19 and 24 if a fulltime student, or over age 19 and unemployable because of a physical or mental disability. In order for the Dependent Death Benefit to be payable, your Dependent must be covered under the Fund at the time of death.

Death Benefits		
Benefit	**Silver/Gold**	**Platinum/Platinum Plus**
Employee Death Benefit	$11,250 – $22,500 depending on your Years of Service at time of death as follows: • Up to 6 years: $11,250 • At least 6 but less than 7 years: $13,500 • At least 7 but less than 8 years: $15,750 • At least 8 but less than 9 years: $18,000 • At least 9 but less than 10 years: $20,250 • 10 or more years: $22,500	$15,000 – $30,000 depending on your Years of Service at time of death as follows: • Up to 6 years: $15,000 • At least 6 but less than 7 years: $18,000 • At least 7 but less than 8 years: $21,000 • At least 8 but less than 9 years: $24,000 • At least 9 but less than 10 years: $27,000 • 10 or more years: $30,000
Dependent Death Benefit (for death of enrolled lawful Spouse; enrolled unmarried Children/stepchildren up to age 19, or between 19 and 24 if they are fulltime students, or over age 19 and unemployable because of a physical or mental disability)	$3,000	$4,000
Burial Expense (in lieu of Employee Death Benefit, where no eligible beneficiary)	Up to a maximum of $2,250	Up to a maximum of $3,000

Accidental Death & Dismemberment (AD&D) Benefits (Employee Only)

In addition to the death benefit outlined above, AD&D benefits are payable if an Employee's bodily Injury or death is effected solely through external, violent, and accidental means and results in any of the losses listed below within 90 days after the date of the accident causing the loss.

If you suffer more than one of the losses listed below from the accident, the Fund will pay you only for the loss for which the largest amount is payable. The total AD&D benefit payable from all causes may not exceed the maximum amount to which you are entitled based on your completed Years of Service.

Loss Qualifying for AD&D Benefits	Benefit
Employee's loss of the entire sight of one eye, or the loss of one hand or one foot	50% of the applicable Employee Death Benefit
Employee's loss of life, loss of entire sight of both eyes; or the loss of both hands or both feet; or loss of one hand and one foot; or one hand or one foot together with the sight of one eye	100% of the applicable Employee Death Benefit

How to File a Claim for Death, Burial or Accidental Dismemberment Benefits

Upon the death of a Participant or an enrolled Dependent, the surviving beneficiary should immediately contact the Fund Office for guidance and assistance. **All claims must be received within one year of death or accidental dismemberment or benefits will not be payable. See section beginning on page 87 for the claims and appeals procedures applicable to Non-Health claims for more information.**

You can download a claim form at **scufcwfunds.com/healthcare/ad-d-benefits** or contact the Fund Office for assistance.

The Scholarship Award and Tuition Assistance Programs

This Chapter provides a summary of the Scholarship Award and Tuition Assistance Programs maintained by the United Food & Commercial Workers Unions and Food Employers Benefit Fund and is not intended to be a complete statement of the rules and regulations governing these programs. In case of any differences between this Chapter and the official plan documents for these programs, the plan documents will prevail. Subject to the applicable provisions of the Collective Bargaining Agreement and applicable law, the Trustees reserve the right to amend, suspend or terminate these programs or any part of these programs at any time.

The Union and Employer Trustees of the United Food & Commercial Workers Unions and Food Employers Benefit Fund take great pride in providing the Scholarship Award and Tuition Assistance Programs as part of your valuable benefit package.

The Scholarship Award Program is designed to recognize Participants and their eligible dependent children who represent outstanding academic, technical, or vocational potential or achievement, dedicated community service and a high degree of personal accomplishment. **In this Chapter, the term "Participant" or "Participants" refers only to Employees and does not refer to a Dependent of an Employee.**

The Tuition Assistance Program is designed to reimburse all or part of your tuition expenses for education, such as undergraduate college and university coursework, technical or vocational training, general education degree courses, career training, or adult education. It can also provide a small reimbursement to you for the cost of your Child's tuition for education in a public or private college or university degree program, or for post-high school technical or vocational training.

The Scholarship Award Program

Who Is Eligible for Scholarship Awards

Employee Eligibility

You are eligible to apply between December and February for a Scholarship Award for the next academic year if you have completed at least one Year of Service as of the prior November.

If you are selected for a Scholarship Award, you must be actively employed in Covered Service during the month the Award is determined in order to receive it.

For the purposes of this Chapter of the SPD, the following definitions apply:

- A "Year of Service" is a period of 12 months of elapsed time of active employment in Covered Service without either a termination of employment for any reason or a transfer to a position that is not Covered Service. A termination of employment shall be ignored if an Employee terminates employment with one Employer and begins working in Covered Service for another Employer within 60 days.
- "Covered Service" is employment covered by a Collective Bargaining Agreement or employment by the Union, UFCW Region 8 States Council, or Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds Administration, LLC, when such entities are bound by an agreement to participate in this Fund.

Dependent Children's Eligibility

Your children are eligible to apply for Scholarship Awards between December and February if you have completed at least three Years of Service as of the prior November and if they meet the following criteria:

- The child must be unmarried;
- He or she must be less than 24 years of age on the date that the Award is made; and
- He or she must be your dependent for purposes of federal income taxes.

Eligible children also include legally adopted children, a child placed with you for adoption or a stepchild principally supported by you. Foster children are eligible provided they meet the foster child requirements of the Fund. Please contact the Fund's eligibility department for more detailed information.

If your child is selected for a Scholarship Award, you must be actively employed in Covered Service during the month the Award is determined in order for your Child to receive it.

Your child does not need to be covered under the Fund's benefits (i.e., medical, dental, etc.) to be eligible for a Scholarship Award.

Spouses and Domestic Partners are not eligible for Scholarship Awards.

Scholarship Awards

You or your children, if eligible, can apply for a Scholarship Award to pursue undergraduate college or university degree programs or post-high school technical or vocational training at the following types of accredited institutions:

- Public and private colleges and universities
- Community colleges
- Trade and technical schools
- Vocational schools

Scholarship Awards are available only to applicants who will be full-time students. The institution or training center must be accredited in accordance with state and local licensing and accreditation requirements. The Scholarship will cover tuition but not housing expenses, books or other incidental fees.

Each year, a Scholarship Selection Committee jointly selected by the Union and Employer Trustees (the "Committee") reviews applications from all eligible Participants and their Children and selects up to 300 winners of Awards made at three levels:

- $10,000
- $5,000
- $2,500

The Scholarships are awarded in April of each year. The Award is valid for the academic year following receipt of the Award by the applicant, and may, subject to certain limitations, be used in subsequent academic years. (Please see Exclusions and Limitations beginning on page 63).

The Committee makes every effort to allocate the Awards between academic and vocational applicants in proportion to the number of qualified applications received in each category in that year. The Award recipients represent all geographic areas under the jurisdiction of the Fund and individual Union Locals and Employers. Please note:

- Awards are determined at the discretion of the Committee, and its decision is final and binding.
- Awards are paid directly to the school to which the recipient has been admitted as necessary to cover tuition expenses.

How Scholarship Award Winners Are Selected

The Committee selects winners of the Scholarship Awards on the basis of the following criteria:

- Academic record
- Leadership record
- Community service and volunteer activities
- Character and personality
- Personal achievement;
- Financial need

How to Apply for a Scholarship Award

The forms that must be completed to apply for a Scholarship Award are available from your Union Local or the Fund Office. They are described below.

Scholarship Application Form

This form must be completed by both the applicant and by the Participant, if different from the applicant.

Follow the Application form instructions carefully. Both the Participant and the applicant, if different, must sign and date the form. Mail the form to the Fund Office, and include all documents requested in the Application instructions, with your official transcripts including SAT scores and a copy of your completed Free Application for Federal Student Aid (FAFSA form), or Student Aid Report (SAR).

Teacher Appraisal Form

This form is available from your Union Local or the Fund Office. Two copies must be completed. First, the applicant and the Participant, if different, should fill out the form. Then, the form should be completed by two teachers of the applicant.

The applicant must sign the applicant section, authorizing the teacher to give the information requested to the Fund Office for administrative purposes.

Give the Teacher Appraisal form to two teachers who have taught courses completed by the applicant. The teachers must attach letters of recommendation to the forms. Submit the completed forms and letters with the Application form.

Determination of Eligibility for Scholarship Awards

Eligibility of a Participant or a Participant's child to apply for a Scholarship Award will be determined when the Application and attachments are received in the Fund Office. Only the Applications of persons who meet the eligibility requirements will be presented to the Committee. If you (or your child) are determined to be ineligible to apply for a Scholarship Award, you will be notified within 60 days of receipt of your Application by the Fund Office.

Application Deadline

Your Application and all associated documentation must be postmarked no later than February 28 in order to be considered for a Scholarship Award for the following academic year. Awards are generally made by April 30. **Late Applications, incomplete Applications, and those missing required documentation will not be accepted.**

Exclusions and Limitations

- The Scholarship Award will not be payable to either you or your child; it will be used only for tuition and will be paid directly to the institution the recipient will be attending.
- The Award will pay only that part of the tuition that exceeds any other financial aid, such as public or private financial assistance, fellowships, scholarships, or grants.
- Scholarship Awards may not be used to cover registration fees, student body fees, activity fees, books, supplies, equipment, tools, meals, lodging, parking, or transportation.
- Scholarship Awards do not cover coursework toward university and college post-graduate degrees. They are applicable only to undergraduate coursework.
- If a Participant or Participant's child is awarded a Scholarship Award, the Participant will not be entitled to reimbursement of any tuition expenses under the Tuition Assistance Program for the period of time and the courses covered by the Scholarship Award.
- No Award will be made for courses at any institution outside the United States except exchange student programs.
- No Award will be made for courses at any institution which does not operate in accordance with state and local licensing or accreditation requirements.
- Scholarship Award balances may be carried over for use in the following academic year. However, Scholarship recipients who do not use their Awards for a 12-month period will forfeit the remaining balances.

The Tuition Assistance Program

Who Is Eligible for Tuition Assistance

Participant Eligibility

You are eligible to apply for Tuition Assistance if you meet the following criteria:

- You have completed at least one Year of Service prior to beginning the course or courses for which you are seeking assistance; and
- You are actively employed in Covered Service during the month in which you begin the course or courses.

Dependent Children's Eligibility

Your children are eligible to apply for Tuition Assistance if you have at least 10 Years of Vesting Credit under the Southern California United Food & Commercial Workers Unions and Food Employers Joint Pension Trust Fund, and you are actively employed in Covered Employment as of the date coursework begins. Your children must also meet the following criteria:

- The child must be unmarried;
- He or she must be less than 24 years of age on the date that the course begins; and
- He or she must be your dependent for purposes of federal income taxes.

Eligible children also include legally adopted children, a child placed with you for adoption or a stepchild principally supported by you. Foster children are eligible provided they meet the foster child requirements of the Fund. Please contact the Fund's eligibility department for more detailed information.

Your child does not need to be covered under the Fund's benefits (i.e., medical, dental, etc.) to be eligible for Tuition Assistance.

Spouses and Domestic Partners of Participants are not eligible for Tuition Assistance.

Tuition Assistance for Participants

The Tuition Assistance Program is available to both full-time and part-time students. It is designed to reimburse Participants up to $500 per calendar year for classes or courses completed in that calendar year. Eligible expenses include tuition expenses for post-high school undergraduate degrees and general education degree classes or courses at the following types of accredited institutions:

- Public and private colleges and universities;
- Community colleges;
- Trade and technical schools; or
- Vocational schools.

In addition, courses through correspondence schools, if accredited, also qualify for tuition assistance.

If the courses you take qualify as Industry Advancement Courses, you can receive reimbursement up to $1,000 for courses completed in a calendar year. An Industry Advancement Course is a class or course approved by the Board of Trustees that improves a Participant's knowledge or skills in a manner that is pertinent to advancement in the Retail Food Industry. For more information about Industry Advancement Courses, please call the Fund Office.

Tuition Assistance for Children's Expenses

You can receive reimbursement of up to $300 per calendar year for classes or courses completed by your eligible dependent children in that calendar year.

Eligible expenses include tuition expenses you pay on behalf of your eligible dependent children for a post-high school undergraduate degree and general education degree courses at any of the institutions listed above.

How to Apply for Tuition Assistance

The forms which must be completed to apply for Tuition Assistance are available from your Union Local or the Fund Office or online at **scufcwfunds.com**.

Please refer to the *Tuition Assistance Application for Participant* form and to the *Tuition Assistance for Child of Participant* form.

Participants

To obtain Tuition Assistance, you must apply by submitting your application to the Fund Office within one year after completing the courses for which you would like tuition reimbursement. To receive reimbursement, send a *Tuition Assistance Application for Participant* form along with a tuition receipt and a copy of your school transcript showing successful completion of the courses.

You can apply for Tuition Assistance for Industry Advancement Courses on the *Tuition Assistance Application for Participants* form. However, please note that to qualify for the Industry Advancement Course benefit, the courses you take must be among those approved by the Board of Trustees. Therefore, you should call the Fund Office in advance before enrolling to determine whether your planned curriculum meets this requirement.

Follow the application form instructions carefully.

Eligible Dependent Children

To obtain Tuition Assistance for an eligible child, submit the *Tuition Assistance Application for Child of Participant* form to the Fund Office within one year after the child has completed the applicable course or courses. Include a receipt for your child's tuition and a copy of his or her school transcript showing successful completion of the courses.

Exclusions and Limitations

- Reimbursement will not be made for registration fees, student body fees, activity fees, books, supplies, equipment, tools, meals, lodging, parking or transportation.
- Reimbursement will not be made for or in connection with any course or other education involving sports, games, recreational activities, travel or hobbies.
- Reimbursement will be made only to the extent that the Participant's or child's covered educational expenses, as defined by the plan document exceed any other financial aid, such as public or private financial assistance, fellowships, scholarships or grants.
- No reimbursement will be made for courses at any institution outside the United States or which does not operate in accordance with state and local licensing or accreditation requirements.
- No reimbursement will be made for fees for seminars and conferences, even if sponsored by an accredited institution and hours are creditable for professional continuing education or credentials.
- No reimbursement will be made for any course for which the applicant has not filed a *Tuition Assistance Application for Participants* form or a *Tuition Assistance Application for Child of Participant* form with the Fund Office within one year after completing the course.
- No reimbursement will be made for tuition expenses for any person who has received a Scholarship Award from the Fund for the period of time for which Tuition Assistance is requested.

Information About Income Taxes

Scholarship Awards

Please check with your own tax advisor to determine if you have any tax consequences as the result of receiving a Scholarship Award for yourself or your dependent children.

Tuition Assistance

Please check with your own tax advisor to determine if you have any tax consequences as the result of receiving Tuition Assistance.

Claims and Appeals Procedure

If a claim for Tuition Assistance is denied, in whole or in part, or if it is determined that you or your dependent child is not eligible to apply for a Scholarship Award, you will receive written notice from the Fund within 90 days (or 180 days under special circumstances). The notice will include specific reasons for the denial, reference to the plan provision that is the basis for the denial, a description of any additional material or information required, and information on steps to take if you want a review.

You will then have 60 days from the date the notice is received to request, in writing, a review of the decision. You may also review pertinent documents and submit comments. The review will be completed by the Board meeting that occurs at least 30 days following receipt of the request for review. In special circumstances, the decision shall be rendered not later than the third meeting following receipt of the request. The decision will be in writing and shall include specific reasons for the decision.

All Scholarship Awards are determined in the discretion of the Scholarship Selection Committee, and there is no right to a review of their determination.

Coordination of Benefits (COB): Other Coverage and Dual Coverage

This Chapter describes the Plan's coordination of benefits rules applicable to benefits provided under the Indemnity PPO Medical Plan. This Chapter does not apply to benefits provided by the Fund-sponsored HMOs (Kaiser Permanente and Anthem Blue Cross), except for ancillary benefits provided by the Fund to such HMO enrollees. Coordination of benefits is generally handled by the Fund Office.

These coordination of benefits (COB) rules apply when the Fund processes a Health Claim of a Participant who (1) also has health coverage under a plan, policy or program that is not provided by the Fund (referred to as "Other Coverage"), or (2) has "Dual Coverage" under this Fund (as defined below).

These COB rules will be used to determine (1) whether this 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), (2) the limits on the Fund's payment obligations when a Participant has Other Coverage and (3) 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.

For purposes of this chapter, the term "you" or "your" refers to a covered Employee.

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

Definition of 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 that provides payment or reimbursement for Hospital, medical, prescription drug, mental health and/or substance abuse, 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, for which the Fund is permitted by law to coordinate benefits.

Other Coverage generally does not include the following: (1) coverage under an individual (i.e., non-group) plan or policy; (2) medical benefits under a group or individual motor vehicle insurance contract; (3) blanket insurance contracts issued pursuant to Section 10270.2(b) or (e) of the California Insurance Code which contain a non-duplication of benefits or excess policy provision; and (4) Medicare supplement policies or coverage under other federal or state governmental plans, unless coordination with such coverage is permitted by law.

Working Spouse/Domestic Partner Rule

If there is other employment-related group health plan coverage available to your Spouse/Domestic Partner, he or she is required to enroll in that plan. Otherwise, the benefits under this Plan will be significantly reduced. See page 10 for more information on the Spouse/Domestic Partner requirement to enroll in other group health plan coverage when offered.

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 this Plan is primary to the Other Coverage, the Fund will pay the amount that it would have paid if there had been no Other Coverage involved (this is referred to as the "Normal Benefit").

When this Plan is secondary to the Other Coverage (i.e., the Other Coverage is primary), then benefits will be determined as follows:

- 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.
- 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. You will still have some out-of-pocket expense even though two plans are involved.

Note that under the "non-duplication of benefits" rule, the Fund will not coordinate with HMO plans, regardless of which plan is considered to be the primary payer, unless required to do so under federal law. In other words, the Fund will not reimburse HMO copays or deductibles.

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.

COB Example 1: Your Other Coverage pays 50%, and this Plan usually pays 75% for medical treatment. Should you have covered medical expenses, your Other Coverage will pay 50% and the Fund will pay 25%, which is the difference between the Fund's payment of 75% and the 50% paid by the Other Coverage. You will pay the remaining 25%.

COB Example 2: If your Other Coverage pays 75%, and this Plan usually pays 75%, 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 it were primary. You will pay the remaining 25%.

Exceptions to Non-Duplication: 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 Participant has Dual Coverage if:

- The Participant has coverage under the Fund both as an Employee and as the Dependent of an Employee (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 the Participant and his/her Spouse/Domestic Partner both have family coverage under the Indemnity PPO Medical Plan; or
- The Participant has coverage under the Fund as a Dependent of two Employees (e.g., the Participant is a Dependent Child whose two parents are both Employees with Fund coverage, each of whom have enrolled the Child in family coverage under the Indemnity PPO Medical Plan).

If both you and your Spouse/Domestic Partner are enrolled in family coverage under the Indemnity PPO Medical Plan, the Fund will pay 100% of covered charges (Eligible Medical Expenses) up to specified Plan maximums or limitations, and there will be no individual or family deductibles or out-of-pocket maximums that must be met before benefits are paid at 100%. Also, because there are no deductibles or co-insurance amounts that you are responsible for, no annual basic HRA contributions will be made on your behalf to offset those costs. Nevertheless, you and your Spouse/Domestic Partner are encouraged to participate in the My Health/My Choices Incentive Program and are eligible to complete up to two Healthy Activities every year to earn HRA contributions that can offset Prescription Drug co-payments for you and your covered Dependents.

Please note that the above "Dual Coverage" exception does not apply if:

- Both you and your Spouse/Domestic Partner are enrolled in the Indemnity PPO 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 PPO Medical Plan and your Spouse/Domestic Partner is enrolled in a Fund-sponsored HMO, or vice versa.
- Both you and your Spouse/Domestic Partner are in a Fund-sponsored HMO.

Contact the Fund Office for additional information.

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.

Which Plan Pays First: Order of Benefit Determination Rules

The Overriding Rules

When a Participant also 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. If the first of the following rules does not establish a sequence or order of benefits, the next rule is applied, and so on, until an order of benefits is established.

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 Medicare, Medicaid, a state Children's Health Insurance Program (CHIP), TRICARE, or another government program, different rules will apply, as specified below.

These order of benefits determination rules are as follows:

Rule 1: Non-Dependent or Dependent

A. 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.

B. There is one exception to this rule: 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.

Rule 2: Dependent Child Covered Under More Than One Plan

If your covered Child also has Other 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:

A. **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:

1. The parents are married or living together (regardless of marital status); or
2. 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.

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.

B. 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, 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.

C. 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:

1. The plan of the custodial parent pays first; and
2. The plan of the spouse of the custodial parent pays second; and
3. The plan of the non-custodial parent pays third; and
4. The plan of the spouse of the non-custodial parent pays last.

D. Non-Parental Coverage: For a covered Dependent 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 (the longer/shorter length of coverage). If, however, the length of coverage is the same, then the Birthday Rule (Rule 2) applies between the Dependent Child's coverage under the Fund and the Child's Other Coverage. For example, if a married Dependent 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, and 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.

Rule 3: Active or Laid-Off/Retired Employee

A. 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.

B. If 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 active plan is primary over the retiree plan.

C. If the Other Coverage does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Rule 4: Continuation Coverage

A. 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, 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.

B. 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 rather than by this rule.

C. If the other plan does not have this rule, and if, as a result, the plans do not agree on the order of benefits, this rule is ignored.

Rule 5: Longer/Shorter Length of Coverage

A. If none of the four previous rules determines the order of benefits, the plan that covered the Participant for the longer period of time pays first; and the plan that covered the same person for the shorter period of time pays second.

B. To determine how long a Participant was 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.

C. The start of a new plan does not include a change:

1. In the amount or scope of a plan's benefits;

2. In the entity that pays, provides, or administers the plan; or

3. From one type of plan to another (such as from a single employer plan to a multiple employer plan).

D. The length of time a Participant is 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 was covered under the plan presently in force.

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.

Administration of COB

1. To administer these COB rules, the Fund reserves the right to:

- Exchange information regarding a Participant's Health Claim(s) with the Other Coverage;
- 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);
- Reimburse a Participant or his/her Other Coverage that made payments that the Fund should have made; or
- 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.

2. 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 to be benefits paid under this Plan, and the Fund will be fully discharged from any liability it may have to the extent of such payment.

3. 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.

4. This Fund will not pay expenses for which a Participant has no liability.

5. If a Participant enrolled in the Fund's Indemnity PPO Medical Plan also has Other Coverage under a pre-paid program (such as an HMO or an Individual Practice Association) through his/her spouse's or other family member's plan, and that Participant incurs expenses normally covered under the HMO, there is no reimbursement of co-payments by this Plan.

6. If this 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.

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 on page 66.

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" 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.

Note: 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 Medicare Entitlement: For a Participant whose entitlement to Medicare is based on age:

1. If the Participant has Fund coverage due to an Employee's current employment status, this Plan is primary to Medicare.
2. If, however, the Participant has retiree or COBRA coverage under the Fund, Medicare will be primary to this Plan.

D. Disability-Based Medicare Entitlement: For a Participant whose entitlement to Medicare is based on disability:

1. If the Participant has Fund coverage due to an Employee's current employment status, this Plan is primary to Medicare.
2. If, however, the Participant has retiree or COBRA coverage under the Fund, Medicare will be primary to this Plan.

E. 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 (following a three month waiting period).

   Exception: If the Participant is already entitled to Medicare on the basis of age or disability when (s)he becomes eligible 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: (1) the first month in which the individual becomes entitled to Medicare Part A on the basis of ESRD; or (2) the first month the individual would have become entitled to (i.e., enrolled in) Medicare part A on the basis of ESRD if he/she had enrolled in such coverage.

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 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 (formerly called Medicare + Choice or Part C) 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.

   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 In-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:** When this Plan is secondary to Medicare, the Plan will estimate Medicare Benefits when there is private-contracting between a Participant with Medicare and a Physician or other practitioner who had decided not to provide services through Medicare.

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.

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 subsection, rather than the "Order of Benefit Determination Rules" above, to determine whether the 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, and if the individual has TRICARE as an active duty service member, 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.

COBRA: Temporary Continuation of Health Care Coverage

Continuation of Coverage (COBRA)

Entitlement to COBRA Continuation Coverage

In compliance with a federal law, the Consolidated Omnibus 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"), but only if 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.

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 the Marketplace, you could be eligible for a tax credit that lowers your monthly premiums for Marketplace-purchased 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 other plan generally does not accept late enrollees. The special enrollment right is also available to you if you continue COBRA Coverage for the maximum time available to you.

Who is Entitled to COBRA Coverage, When, and for How Long

Qualified Beneficiaries

Under the law, only Qualified Beneficiaries are entitled to COBRA Coverage. A Qualified Beneficiary is an Employee or the Spouse or Child of an Employee who loses coverage under the Fund 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.

- 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.

Each Qualified Beneficiary **has an independent right to elect COBRA** Coverage. For example, the Employee's Spouse may elect COBRA Coverage even if the Employee does not. COBRA Coverage may be elected for only one, some, or for all Dependents who are Qualified Beneficiaries. Furthermore, covered Employees may elect COBRA Coverage on behalf of their Spouses, and covered parents/legal guardians may elect COBRA Coverage for a minor Child.

Qualifying Events

Qualifying Events (which are specified in the law) are those shown in the chart below. **A Qualifying Event triggers the opportunity to elect COBRA Coverage, but only if the covered individual *loses* health care coverage under the Fund as a result of the Qualifying Event.** If a covered individual has a Qualifying Event but, as a result, ***does not lose*** their health care coverage under the Fund (e.g., the Employee continues working even though entitled to Medicare), then 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 (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 (for other than 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

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 example, if the Qualifying Event occurred on January 5, then COBRA Coverage would begin on the following February 1, regardless of when your Fund coverage actually ends.

An 18-month period of COBRA Coverage may be extended under certain circumstances (described in other sections of this chapter on extending COBRA in the case of a second Qualifying Event or disability). In addition, 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.

The maximum COBRA Coverage period may be cut short for the reasons described in the section on "Early Termination of COBRA Coverage" that appears later in this chapter.

Initial COBRA Notice

A general 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 (1) a Qualifying Event occurs within this 90-day period, and a timely COBRA Election Notice is furnished, or (2) 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.

You Must Notify the Fund of Certain Qualifying Events

When the Qualifying Event is divorce or a Child ceasing to be a Dependent Child as defined under the Plan, **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 (1) your name, (2) the name(s) of your Dependent(s), if applicable, (3) your mailing address and telephone number, (4) the mailing address(es) and telephone number(s) of your Dependent(s), if different, (5) the Qualifying Event, (6) the date of the event, and (7) 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 (a) it contains sufficient information for the Fund 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 (b) the individual provides additional information requested by the Fund within a reasonable period of time, not to exceed thirty (30) days.

NOTE: If such notice is not received by the Fund Office within this 60-day period, the Qualified Beneficiary will not be entitled to elect COBRA Coverage.

An Employee or Dependent who fails to notify the Fund 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 any means available 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 in order 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.

How to Elect COBRA Coverage

When:

A. **Your Employer notifies the Fund Office** that your employment has terminated, your hours have been reduced, or you have died; or

B. ***You* timely notify the Fund Office** that you have divorced or a Dependent Child has lost Dependent 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 you have divorced or that a Dependent Child has lost Dependent 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, and may be provided to: (1) 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/or (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 shows that the Child resides with the addressee.

Under the law, you and/or your covered Dependents will then have only 60 days after the later of (1) the date of the COBRA election notice, or (2) 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.

NOTE: If you and/or any of your covered Dependents do not elect COBRA Coverage within this 60-day election period, you and/or your Dependent(s) will not be provided COBRA Coverage and will have no group health coverage from this Plan after the date coverage ends.

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.

The COBRA Coverage That Will Be Provided

If you elect COBRA Coverage, you will be entitled to the same health coverage that you had right before the occurrence of the Qualifying Event that caused your health coverage under the Fund to end, but you must pay for it.

Each Qualified Beneficiary electing COBRA Coverage may choose from the following two options:

- **Core Benefits Only:** medical and prescription drug coverage only; or
- **Core Benefits Plus:** medical, prescription drug, dental, and vision coverage.

COBRA coverage does not include Death, Accidental Death & Dismemberment, or other Fund benefits not listed above.

Once you have made your election for either Core Benefits Only or Core Benefits Plus, you may not change it.

In addition, you can only choose the plan of benefits 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, you may not enroll in the Indemnity PPO Medical Plan when you apply for COBRA Coverage, except in the following situations: (1) during an open enrollment period; or (2) if you are moving outside the HMO'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 Special Enrollment and Open Enrollment rights. For example, you may change medical plans if eligible (e.g., Indemnity to HMO) during the Fund's annual Open Enrollment period.

Paying for COBRA Coverage (The Cost of COBRA)

Any person who elects COBRA Coverage must pay for it. The Fund is permitted to charge 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.

Each person will be told the exact dollar charge for the COBRA Coverage that is in effect at the time he or she becomes entitled to it. The cost of the COBRA Coverage may be subject to future increases during the period it remains in effect. COBRA enrollees will be advised in advance of any COBRA premium adjustments.

NOTE: The COBRA election notice will contain premium rate information for COBRA Coverage. After your first payment, you must make payments on a monthly basis. You are responsible for making timely payments for COBRA Coverage whether you receive an invoice or not.

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). Payment is considered effective on the date that it is postmarked or hand-delivered to the Fund 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, Qualified Beneficiaries will receive COBRA payment coupons that can be used when paying COBRA premiums. In addition, claims incurred during the COBRA election period will be processed in accordance with Plan terms.

Monthly COBRA Payments and Grace Periods

After the initial COBRA premium payment, **subsequent payments** 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 effective on the date that it is postmarked or hand-delivered to the Fund 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.

What if the Full COBRA Premium Payment is Not Made When Due?

If the Fund receives a COBRA premium payment that is not for the full amount due, then the Fund Office will determine if the COBRA premium payment is short by an amount that is "significant." A premium payment will be considered **significantly short** of the required premium payment if the shortfall exceeds the lesser of $50 or 10% of the required premium payment.

If there is a significant shortfall, the COBRA continuation coverage will end as of the date for which the last full COBRA payment was made.

If there is not a significant shortfall, the Fund Office will notify the Qualified Beneficiary of the deficient amount and allow a reasonable period of 30 days to pay the shortfall. If the shortfall is paid within the 30-day time period, COBRA coverage will continue for the month in which the shortfall occurred. If the shortfall is not paid within the 30-day time period, COBRA continuation coverage will end as of the date for which the last full COBRA premium payment was made (which may result in mid-month termination of COBRA coverage).

Confirmation of Coverage Before Election or Payment

If a Health Care Provider requests confirmation of the coverage of a Qualified Beneficiary who has (1) elected COBRA Coverage and the amount required for COBRA Coverage has not been paid while the grace period is still in effect or (2) is within the COBRA election period but has not yet elected COBRA, COBRA Coverage will be confirmed, but with notice to the Health Care Provider that the cost of the COBRA Coverage has not been paid, that no claims will be paid until the amounts due have been received, and that the 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.

Addition of 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 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.

Notice of Unavailability of COBRA Coverage

In the event the Plan 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: (1) 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 shows that the Child resides with the addressee.

Extended COBRA Coverage When a Second Qualifying Event Occurs During an 18-Month COBRA Period

If, during an 18-month period of COBRA Coverage 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 Plan, the original 18-month maximum COBRA Coverage period will be extended to 36 months for any individual who (1) was your Dependent on the first Qualifying Event date and (2) 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.

Notifying the Plan

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 Plan 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 (1) your name, (2) the name(s) of your Dependent(s), if applicable, (3) your mailing address and telephone number, (4) the mailing address(es) and telephone number(s) of your Dependent(s), if different, (5) the second Qualifying Event, (6) the date of the second Qualifying Event, and (7) 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: (1) it contains sufficient information for the Fund 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 (2) the individual provides additional information requested by the Fund within a reasonable period of time, not to exceed thirty (30) days.

This extended period of COBRA Coverage is *not* 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 period of COBRA Coverage.

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 section). As a result, if an Employee experiences 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.

In no case is anyone entitled to COBRA Coverage for more than a total of 36 months.

Extended COBRA Coverage in Certain Cases of Disability During an 18-Month COBRA Period

If, prior to the Qualifying Event or during the first 60 days of an 18-month period of COBRA Coverage, the Social Security Administration makes a formal determination that you or a covered Spouse or Dependent 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 the 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).

1. This extension is available only if:
   - the Social Security Administration 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 Plan is timely notified of the individual's disability.

Notifying the Plan: You (or another family member) must notify the Plan by sending written notice to the Fund Office of the Social Security Administration's determination within 60 days after the later of (1) the date of the SSA determination or (2) 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 (1) your name, (2) the name(s) of your Dependent(s), (3) your mailing address and telephone number, (4) the mailing address(es) and telephone number(s) of your Dependent(s), if different, (5) the name of the disabled person, (6) a statement that the notice is a request for an extension of COBRA due to a disability, (7) the date the disability began, and (8) appropriate documentation in support of the disability, including a copy of the written Social Security Administration disability award documentation.

A timely notice that does not contain all of the information listed above is considered valid if (1) it contains sufficient information for the Fund to determine the group health plan, the covered Employee and Qualified Beneficiary(ies), the disability, and the date on which the disability occurred, and (2) the individual provides additional information requested by the Fund within a reasonable period of time, not to exceed thirty (30) days.

2. 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. The disability extension will terminate on the first day of the month that begins at least thirty (30) days after the date of the SSA's final determination that you or your Dependent is no longer disabled. The Fund Office must be notified within 30 days of the determination by the Social Security Administration that an individual is no longer disabled.

Early Termination of COBRA Coverage

Once COBRA Coverage has been elected, it may be cut short (i.e., terminated early) 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 thirty (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 to 29 months due to the disability of the Qualified Beneficiary, the disabled beneficiary is determined by the Social Security Administration to **no longer** be disabled;
5. The Fund 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.

Notice of Early Termination of COBRA Coverage

The Fund will notify a Qualified Beneficiary if his or her COBRA Coverage terminates earlier than 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 Plan 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) 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 shows that the Child resides with the addressee.

Claims Incurred and COBRA Premiums Paid Following the Termination of COBRA

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.

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 from the Qualified Beneficiary.

Entitlement to Convert to an Individual Health Plan after COBRA Coverage Ends (for HMO Enrollees Only)

If you have HMO coverage, 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 PPO Medical Plan or the Dental Plans.

Cal-COBRA Coverage (for HMO Medical Benefits Only)

A COBRA Qualified Beneficiary who is enrolled in an HMO and who has exhausted his or her maximum COBRA Coverage period of less than 36 months may be entitled to continue Fund HMO 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.

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 must notify the Fund Office:

1. Within 60 days of a divorce.
2. Within 60 days of a second qualifying Event that is the Employee's death, divorce or loss of Dependent Child status
3. 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.
4. Within 60 days if a covered Child ceases to qualify as a Dependent Child.
5. Promptly if an individual has **changed their address, becomes entitled to Medicare, or is no longer disabled**.

Important Reminder: If you get divorced or terminate your Domestic Partnership, you must notify the Fund Office immediately.

If you have not notified the Fund Office of your divorce or the termination of your Domestic Partnership, 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/domestic partner 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.

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.

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.

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.

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.

Additionally, you (and any Dependents covered under the Fund on the day your leave started) may also be eligible to elect COBRA Coverage.

Note that USERRA Coverage is an alternative to COBRA Coverage. Therefore, either COBRA Coverage or USERRA Coverage can be elected. Contact the Fund Office to obtain a copy of the COBRA or USERRA election forms. Completed USERRA election forms must be submitted to the Fund Office in the same time frames 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 chapter for more details.

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 time frame 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.

Reinstatement of Fund Coverage Upon Return to Employment After Discharge from the Armed Forces:

When you are discharged from military service (not less than honorably), your Fund coverage will be reinstated on the day you return to work, provided you:

- Submit an application for reemployment to the Employer no later than 90 days from the date of discharge from the military, if your period of service was more than 180 days;
- Submit an application for reemployment to the Employer no later than 14 days from the date of discharge, if your period of service was 31 days or more but less than 180 days; or
- Report to your Employer at the beginning of the first full regularly scheduled working period on the first calendar day following discharge (plus travel time and an additional 8 hours), if your period of service was less than 31 days.

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

You must notify the Fund Office in writing within the time periods listed above. 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.

Questions regarding your entitlement to USERRA Coverage should be directed to the Fund Office.

Claim Filing and Appeal Information

This Chapter describes the claims and appeals procedures and external review process applicable to the benefits provided under the Benefit Fund. Unless expressly stated, **this Chapter does not describe the claims and appeals procedures and external review process applicable to benefits provided by the Benefit Fund-sponsored HMOs (Kaiser Permanente and Anthem Blue Cross) nor does it contain claims and appeals procedures applicable to the Dental Plan**. For the claims and appeals procedures applicable to those plans, please contact the Fund Office or, for the HMOs, review the HMO's Evidence of Coverage booklet.

For the purposes of this Chapter, the term "you" and "yours" refers to a Claimant or a Claimant's Authorized Representative. The terms "Claimant" and "Authorized Representative" are defined below.

Definitions

Claim: A request for a Plan benefit made by a Claimant or an Authorized Representative of a Claimant in accordance with the Plan's claims and appeals procedures and external review process, described in this Chapter.

A Claim is not (1) a mere request for information about Plan benefits, (2) a dispute concerning eligibility for Plan benefits, including COBRA coverage, that is unrelated to any specific Claim, (3) the presentation of a prescription to a pharmacy, or (4) a request for prior approval where prior approval is not required by the Plan, and the Fund Office's review of such requests and disputes will not be subject to the requirements and timelines described in this chapter.

There are three types of Claims, as follows: (1) Health Claims; (2) Disability Claims; and (3) Non-Health Claims. The rules for submitting, processing and appealing a Claim depends on the type of Claim filed.

Claimant: A Participant who submits a Claim.

Concurrent Care Claim: A Plan decision to reduce or terminate a pre-approved ongoing course of treatment before the end of the approved treatment, and that decision is considered the denial of a Health Claim. You will be notified of such denial in advance of the reduction or termination and be given the opportunity to appeal and obtain a determination on appeal before treatment is reduced or terminated. A Concurrent Care Claim also refers to a type of Health Claim that is a request by you to extend a pre-approved course of treatment. The services that will receive concurrent care review are listed in the Utilization Management Chapter in this document.

Disability Claim: A Claim for benefits under the Plan with respect to any over-age Dependent Child, filed after April 1, 2018, involving a determination by the Plan as to whether or not the Child is disabled and eligible for extended coverage due to disability.

Health Claim: A Claim for health care benefits under the Fund's Indemnity PPO Medical Plan, including vision, podiatric, chiropractic, acupuncture, orthodontic, prescription drugs, mental health/substance abuse, and Employee Member Assistance Program (EMAP) benefits, as well as a Claim for ancillary benefits provided under the Fund to Participants enrolled in the Fund-sponsored HMOs. There are four types of Health Claims: Post-Service Claims, Pre-Service Claims, Urgent Care Claims, and Concurrent Care Claims.

Post-Service Claim: A Health Claim for which approval is not required prior to obtaining services and that involves only the payment or reimbursement of the cost of the care that has already been provided. A paper claim and an electronic bill, submitted for payment after services have been provided, as well as Claims for services received in an Emergency, are examples of Post-Service Claims. Also, a Rescission of Coverage will be treated as a denied Post-Service Claim.

Pre-Service Claim: A Health Claim that is a request for benefits, where the Plan conditions payment, in whole or in part, on the approval of the benefit in advance of obtaining health care.

Rescission of Coverage: 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. The Plan is permitted to rescind coverage if a Participant (or a person seeking coverage on behalf of the 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.

Non-Health Claim: A Claim for Death, Accidental Death & Dismemberment, or Industry Vacation benefits.

Urgent Care Claim: A Pre-Service Claim where the usual time for processing the Claim either (1) could seriously jeopardize your life, health or ability to regain maximum function or (2) would subject you to severe pain that cannot be adequately managed without the care that is the subject of the Claim. Your attending provider will determine whether a Claim is an Urgent Care Claim, and the Appropriate Claims Administrator (e.g., Anthem, HMC or OptumRx) will defer to such determination.

Use of an Authorized Representative

You may designate someone as your Authorized Representative to be responsible for handling your Claim, appeal, or request for external review, as applicable.

Generally, your designation must be in writing, and you may obtain a form for this purpose from the Fund Office or your Union Local. In the case of Urgent Care Claims, however, a health care professional with knowledge of your medical condition will be permitted to act as your Authorized Representative without your written designation.

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.

Claims and Appeals Procedures — Health Claims

Appropriate Claims Administrator

The "Appropriate Claims Administrator" means either the Fund Office or an organization under contract with the Plan to determine the Plan's payment or financial responsibility, by applying the terms of the Plan to a Health Claim and/or an appeal of a denied Health Claim.

Health Claims are decided by several different Appropriate Claims Administrators, depending on which type of benefit is being sought. These Appropriate Claims Administrators are shown in the chart on this page. (For contact information for each Appropriate Claims Administrator, see the Quick Reference Chart in the front of this document.)

Appropriate Claims Administrator	Types of Health Claims Processed
Fund Office	• Post-Service Claims for medical care • All Claims for prescription drugs obtained from a non-Participating Pharmacy (i.e., an out-of-network pharmacy). • All Claims for vision, podiatric (other than Pre-Service Claims for podiatric benefits provided by Podiatry Plan, Inc. network podiatrists), chiropractic, acupuncture, dental and orthodontic care.
Anthem Blue Cross (Utilization Management Company)	Pre-Service, Urgent Care and Concurrent Care Claims for medical care, including hospital stays.
HMC (Behavioral Health/EMAP Program)	Claims for EMAP, behavioral/mental health and substance abuse services.
Optum Rx (Prescription Drug Program)	Claims for prescription drugs obtained from Participating Pharmacies, including Pre-Service and Urgent Care Claims for drugs requiring pre-approval (as described in the Drug row of the Schedule of Medical Benefits), as well as exceptions to the MPD program.
Podiatry Plan, Inc. (Podiatry Benefits)	Pre-Service Claims for podiatric benefits provided by Podiatry Plan, Inc. network podiatrists.

Filing a Health Claim

Health Claims must be filed as follows:

- All Claims for medical care must be submitted to Anthem Blue Cross.
- All Claims for EMAP, behavioral/mental health, and substance above services must be submitted to HMC.
- All claims for prescription drugs obtained from a Participating Pharmacy must be submitted to Optum Rx. (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).
- All claims for podiatric care provided by Podiatry Plan podiatrists must be submitted to Podiatry Plan, Inc.
- All other claims (e.g., acupuncture, chiropractic, vision, orthodontic, and prescription drugs obtained from a non-participating pharmacy) must be filed with the Fund Office (6425 Katella Avenue, Cypress, CA 90630-5238 or P.O. Box 6010, Cypress, CA 90630-0010).

PPO Providers, Participating Pharmacies, Podiatry Plan, Inc. network podiatrists, and panel orthodontists will submit Claims for you. Other providers (generally Non-PPO Providers and vision providers) may also submit Claims on your behalf. Claims submitted by your Provider will be processed as if they were filed by you. If you need to file a Claim yourself, you can request a Medical Claim form from the Fund Office or a Union Local.

Claims must be filed within one (1) year after the date of service or they will be denied. If a PPO Provider does not file a Claim on time, the Provider can bill you only for the copayment or coinsurance you would have paid if the Provider had filed on time.

Processing a Health Claim

For a Health Claim processed by Anthem, HMC, OptumRx or Podiatry Plan, Inc.: *Your Health Claim, including a Pre-Service, Urgent Care Claim or Concurrent Claim will be processed in accordance with the Appropriate Claims Administrator's own procedures, which are not discussed in this Chapter. For a copy of the Appropriate Claims Administrator's procedures, contact the Fund Office or the Appropriate Claims Administrator.*

Note: The rules shown below in this section entitled "Processing a Health Claim" apply to all Health Claims, regardless of which Appropriate Claims Administrator is processing the Claim.

Failure to Properly File a Pre-Service or Urgent Care Claim

If a communication from a Claimant is received by the Fund Office that fails to follow the Plan's procedures for filing Pre-Service Claims or Urgent Care Claims, but names you, a specific medical condition or symptom, and a specific treatment, service, or product for which approval is requested, you will be notified of the proper procedures to follow. This notice will be provided within five days after receipt of the communication, or within 24 hours for an Urgent Care Claim. This notice may be oral, unless you request written notice.

Time Period for Processing a Claim

Post-Service Claims. A Post-Service Claim will be processed within 30 days after it is received. This period may be extended by up to an additional 15 days if necessary due to matters beyond Appropriate Claims Administrator's control, or longer if you are asked to submit information necessary to process your Claim. You will be notified of any extension before it is taken, the reason for it, and the date a decision is expected. If asked to submit information necessary to decide a Claim, you will be given at least 45 days to respond, and the time for the decision will be suspended from the date of the extension notice to the earlier of the date you respond or the due date set by the Appropriate Claims Administrator. You may voluntarily agree to extend the time for processing your Claim.

Pre-Service Claims. A Pre-Service Claim will be processed within 15 days after it is received by the Appropriate Claims Administrator. The Appropriate Claims Administrator may extend this period for up to an additional 15 days if necessary due to matters beyond its control, or longer if you are asked to submit information necessary to process your Claim. You will be notified of any extension before it is taken, the reason for it, and the date a decision is expected. If asked to submit information necessary to decide a Claim, you will be given at least 45 days to respond, and the time for the Appropriate Claims Administrator's decision will be suspended from the date of the extension notice to the earlier of the date you respond or the due date set by the Appropriate Claims Administrator. You may voluntarily agree to extend the time for processing your Claim.

Urgent Care Claims. An Urgent Care Claim will be processed within a reasonable time, but not later than 72 hours after it is received by the Appropriate Claims Administrator. Notice of the decision on an Urgent Care Claim may be provided orally, followed by a written notice within three days. If the Appropriate Claims Administrator does not receive sufficient information to decide an Urgent Care Claim, it will notify you or your physician of such failure as soon as possible, but not later than 24 hours after receipt of the insufficient information. You will be afforded a reasonable amount of time, but not less than 48 hours, to provide the specified information. After receipt of the specified information, the Appropriate Claims Administrator will provide its decision as soon as possible, but in no case later than 48 hours after the earlier of its receipt of the specified information, or the end of the period afforded you to provide the additional information.

Concurrent Care Claims. If the Appropriate Claims Administrator (e.g., Anthem or HMC) has approved an ongoing course of treatment to be provided to you over a period of time or a number of treatments, a reduction or termination of the course of treatment before the end of such period of time or number of treatments (other than by amendment or plan termination) is a Claim denial. The Appropriate Claims Administrator will notify you of such denial in advance of the reduction or termination and allow you to appeal and obtain a determination on appeal before the benefit is reduced or terminated.

If you request that a course of treatment be extended beyond the period of time or number of treatments initially approved and the request is an Urgent Care Claim, the request will be decided as soon as possible, and you will be notified of the decision not later than 24 hours after receipt of the request, but only if your 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 not later than 72 hours after your request is made.

Contents of Initial Denial Notice. If your Health Claim is denied, in whole or in part, you will receive an EOB that:

A. Identifies the Claim involved and includes the date 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 the Plan's standard(s), if any, that was used in denying the Claim;

C. Refers to the specific Plan provision(s) on which the denial is based;

D. States that the Plan will provide you, free of charge, with the applicable diagnosis and treatment codes (and their meanings) if requested in writing;

E. States that you are entitled to receive, upon request, free access to and copies of documents relevant to your Claim;

F. Describes any additional material or information necessary for you to perfect your Claim and an explanation of why such material or information is necessary;

G. Describes the Plan's internal review procedures, including the time limits applicable to such procedures and information on how to initiate an appeal, as well as the Plan's external review process and the time limits applicable to such process;

H. For denials of Urgent Care Claims only: Describes the expedited review process applicable to such Claims;

I. Includes a statement of the Claimant's right to bring a civil action under ERISA Section 502(a) following either the denial of your Claim on appeal or the denial of your Claim under the Plan's external review process;

J. 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; and

K. States, if applicable, that an explanation of the scientific or clinical judgment for the decision will be provided to you, free of charge and upon request, if the denial is based on a medical necessity or experimental treatment or similar exclusion or limit.

Filing and Processing an Appeal of a Denied Health Claim

If your Health Claim is denied, in whole or in part, you may file an appeal. Appeals must be submitted to the Appropriate Claims Administrator, as follows:

- Appeals of denied Pre-Service, Urgent Care and Concurrent Care Claims for medical care, including Hospital stays must be submitted to Anthem.
- Appeals of denied Pre-Service and Urgent Care claims for prescription drugs from Participating Pharmacies requiring pre-approval, as well as exceptions to the MPD program, must be submitted to OptumRx.
- Appeals of denied Pre-Service, Urgent Care and Concurrent Care Claims for EMAP, behavioral/mental health and substance abuse services must be submitted to HMC.
- Appeals of denied Pre-Service Claims for podiatric benefits from Podiatry Plan, Inc. network podiatrists must be submitted to Podiatry Plan, Inc.
- **All other appeals, including appeals of denied Post-Service Claims, must be filed with the Fund Office.**

For appeals initially decided by Anthem, HMC, OptumRx or Podiatry Plan, Inc. only: You must file your appeal within 180 days of receipt of an EOB or other adverse benefit determination. Any appeal submitted to Anthem, HMC, OptumRx or Podiatry Plan Inc., will be processed in accordance with that Appropriate Claims Administrator's own appeals procedures, which are not discussed in this Chapter. For a copy of the Appropriate Claims Administrator's procedures, contact the Fund Office or the Appropriate Claims Administrator. If, after exhausting the appeals process

through the Appropriate Claims Administrator, 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 shown 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 only: You must file your appeal with the Fund Office within 180 days after receipt of an EOB or other adverse benefit determination.

Your appeal must be in writing. You can use the "Appeal Form" available on the Fund's website or by calling the Fund Office. If you do not use this form, you must make sure that your appeal includes your name, mailing address, telephone number and the basis of your appeal. An appeal of an Urgent Care Claim, however, may be submitted orally.

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. In addition, you will be provided, automatically and free of charge: (1) any new or additional evidence considered, relied upon, or generated in connection with your Claim; and (2) 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. If the Plan receives new or additional evidence or rationale so late in the Claim filing or Claim appeal process that you would not have a reasonable opportunity to respond, the period for providing a final determination is delayed until such time as you have had such an opportunity.

1. 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.
2. Your appeal 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 the Claim, nor the subordinate of such individual. The Board or Committee will make an independent determination and will not afford deference to the initial review. You do not have the right to appear personally before the Board or Committee unless it concludes that such an appearance would be of value in enabling it to perform its obligations.
3. If a denial was based in whole or in part on a medical judgment, including whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the Board or Committee will consult with a health care professional who has experience in the field of medicine involved in your Claim. This health care professional will not be the individual who was consulted in connection with the initial Claim denial, nor the subordinate of any such individual. If you request, we will identify any medical or vocational experts whose advice was obtained on behalf of the Plan in connection with the denial of the Claim, even if the advice was not relied upon in denying the Claim.

Time Period for Processing an Appeal

Post-Service Claims. Your appeal will be decided by the Board of Trustees or its designee, the Appeals Committee, at its next regularly scheduled meeting that occurs at least 30 days following receipt of your appeal. If special circumstances require an extension of time for processing, the decision will be made by the third such meeting following receipt of your appeal. You will be notified in writing of any extension before it is taken, the reason for it, and the date a decision is expected.

If the extension is due to your failure to submit information necessary to decide the appeal, and the extension notice specifically describes the required information, you will be given at least 45 days from the receipt of the extension notice within which to provide such information. The time period for making the decision will be suspended from the date on which the extension notice is sent to you to the earlier of:

- The date on which the Plan receives your response; or
- The date set by the Plan for furnishing the requested information.

You may voluntarily agree to extend the time for the Board or Committee to process your appeal.

You will be notified by mail within five days after the Board or Committee makes its decision.

Pre-Service Claims. You will be provided with a written notice of the decision within 30 days after the appeal is filed.

Urgent Care Claims. You will be provided with a notice of the decision as soon as possible, but not later than 72 hours after the appeal is filed. The notice of the decision may be provided orally, by facsimile, or by other similarly expeditious method, followed by a written denial notice within three days.

Concurrent Care 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 the 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 Care Claim.

Contents of Appeal Denial Notice. If your Claim is denied on appeal, in whole or in part, you will receive a written denial notice that contains the following:

A. Information sufficient to identify the Claim involved, including the date of service, the Health Care Provider, and the Claim amount (if applicable).

B. A discussion of the specific reason(s) for the denial of the Claim on appeal, the denial code (and its corresponding meaning), and a description of the Plan's standard(s), if any, that was used in denying the Claim on appeal.

C. A statement of your right to receive free of charge, if requested, the applicable diagnosis and treatment codes (and their meanings).

D. The specific Plan provision(s) on which the denial on appeal is based.

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

F. A statement of your right to request an external review by an independent review organization, including a description of the external review process.

G. A statement of the Claimant's right to bring an action under ERISA Section 502(a).

H. If applicable, a statement that an internal rule, guideline, protocol or other similar criterion was relied upon in denying the 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.

I. If the denial of a Claim 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.

Recourse after Denial of Health Claim on Appeal

If a Health Claim is denied on appeal, in whole or in part, the Claimant may bring an action for benefits under ERISA Section 502(a). Under certain circumstances, however, the Claimant or his/her Authorized Representative can first request that the Claim be reviewed by an independent review organization under the Plan's external review process (see the section on external review, below). If the Claim is denied on external review, the Claimant may then choose to bring an action under ERISA Section 502(a).

This concludes the internal claims and appeals procedures with respect to Health Claims under this Plan.

External Review Process — Health Claims Only

This voluntary external review process is intended to comply with the Affordable Care Act (ACA) external review requirements. For purposes of this section on the external review process, references to "Plan" include the Plan and its designee(s).

1. **External review is only available in certain cases.** You may seek external review of your denied Health Claim by an Independent Review Organization (IRO) if all the following requirements are satisfied:
   - **a.** The denial either (1) involves medical judgment (as determined by the IRO), including, but not limited to, those based on the Plan's requirements for medical necessity, appropriateness, health care setting, level of care, or effectiveness of a covered benefit, or a determination that a treatment is experimental or investigational, or for a wellness program that includes a health-factor based reward, an adverse review decision or entitlement to a reasonable alternative standard for a reward, or (2) concerns a Rescission of Coverage (retroactive elimination of coverage), regardless of whether the rescission has any effect on any particular benefit at that time.
   - **b.** The denial was not based on ineligibility for coverage.
   - **c.** You have exhausted (or are "deemed" to have exhausted) the Plan's internal claims and appeals procedures described above.
   - **d.** You have provided all of the information and forms required to process an external review.
2. **External review is not available for any other types of denials.** In addition, this **external review process is not available** for Non-Health Claims, Disability Claims or Claims for dental, orthodontic or vision benefits.

3. There are two types of external review outlined below: standard external review (for Non-Urgent Claims) and expedited external review (for Urgent Care Claims). There are special rules for expedited external review, including eligibility and timing requirements, which are described in more detail below

Standard External Review (for Non-Urgent Claims)

Requesting External Review. You may request an external review of your Health Claim after it has been denied on appeal. Your request for external review must be made in writing and must be submitted to the Fund Office **within four months of the date of your appeal denial notice**.

Preliminary Review by the Fund Office. Within five business days of the Plan's receipt of your request, the Plan will complete a preliminary review to determine whether the request is eligible for external review by considering the following factors:

A. Whether you are/were covered under the Plan at the time the health care item or service is/was requested or provided;

B. Whether the Adverse Determination satisfies the above-stated requirements for external review (i.e., the Claim denial involves medical judgment or there has been a Rescission of Coverage) and does not, for example, relate to (1) your failure to meet the requirements for eligibility under the terms of the Plan, (2) a denial that is based on a contractual or legal determination, or (3) a failure to pay premiums causing a retroactive cancellation of coverage;

C. Whether you have exhausted (or are deemed to have exhausted) the Plan's internal claims and appeals procedures (except, in limited, exceptional circumstances when under the regulations you are not required to do so); and

D. Whether you have provided all of the information and forms required to process an external review.

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

A. If your request is complete and eligible for external review.

B. If your request is complete but not eligible for external review, the notice will include the reasons for its ineligibility, and contact information for the Employee Benefits Security Administration (toll-free at 866-444-EBSA (3272)).

C. If your request is not complete, the notice will describe the information or materials needed to complete the request, and allow you to complete the request for external review within the four-month filing period, or within a 48-hour period following receipt of the notification, whichever is later.

Review by an Independent Review Organization (IRO). If the request is complete and eligible for external review, the Plan will assign the request to an IRO, which will conduct the external review. (Note that the IRO is not eligible for any financial incentive or payment based on the likelihood that the IRO would support the denial of benefits. The Plan may rotate assignment among IROs with which it contracts.) Once the Claim is assigned to an IRO, the following procedure will apply:

A. The assigned IRO will timely notify you in writing of the request's eligibility and acceptance for external review, including directions about how you may submit additional information regarding your Claim (generally, you are to submit such information within 10 business days).

B. Within five business days after the external review is assigned to the IRO, the Plan will provide the IRO with the documents and information the Plan considered in making its Adverse Determination.

C. If you submit additional information related to your Claim to the IRO, the assigned IRO must, within one business day, forward that information to the Plan. Upon receipt of any such information, the Plan may reconsider its Adverse Determination that is the subject of the external review. Reconsideration by the Plan will not delay the external review. However, if upon reconsideration, the Plan reverses its Adverse Determination, the Plan will provide written notice of its decision to you and the IRO within one business day after making that decision. Upon receipt of such notice, the IRO will terminate its external review.

D. The IRO will review all of the information and documents timely received. In reaching a decision, the IRO will review the Claim de novo (as if it is new) and will not be bound by any decisions or conclusions reached during the Plan's internal claims and appeals process. However, the IRO will be bound to observe the terms of the Plan to ensure that the IRO's 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.

In addition to the documents and information provided, the assigned IRO, to the extent the information or documents are available and appropriate, may consider additional information, including information from your medical records, recommendations or other information from your treating (attending) Health Care Providers, other information from you or the Plan, reports from appropriate health care professionals, appropriate practice guidelines and applicable evidence-based standards, the Plan's applicable clinical review criteria and/or the opinion of the IRO's clinical reviewer(s) and/or legal expert(s).

E. The assigned IRO will provide written notice of its final external review decision to you and the Fund Office **within 45 days** after the IRO receives the request for the external review.

1. If the IRO's final external review reverses the Plan's adverse determination, upon the Plan's receipt of the notice of such reversal, the Plan will immediately provide coverage or payment for the reviewed Claim. However, even after providing coverage or payment for the Claim, the Plan may, in its sole discretion, seek judicial remedy to reverse or modify the IRO's decision.
2. If the final external review upholds the Plan's Adverse Determination, the Plan will continue not to provide coverage or payment for the reviewed Claim. If the Claimant is dissatisfied with the external review determination, he/she may seek judicial review as permitted under ERISA Section 502(a).

F. The assigned IRO's decision notice will contain the following:

1. A general description of the reason for the request for external review;
2. 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);
3. The date that the IRO received the request to conduct the external review and the date of the IRO decision;
4. References to the evidence or documentation considered in reaching its decision, including the specific coverage provisions and evidence-based standards;
5. 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;
6. A statement that the IRO's determination is binding on the Plan (unless other remedies may be available to you or the Plan under applicable State or Federal law); and
7. Current contact information, including phone number, for any applicable office of health insurance consumer assistance or ombudsman established under the Affordable Care Act to assist with external review processes.

Expedited External Review (for Urgent Care Claims)

You may request an expedited external review if:

1. Your initial Claim denial involves a medical condition for which the time frame for completion of an expedited internal appeal would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function, and you have filed a request for an expedited internal appeal; or
2. The denial of your Claim on appeal involves a medical condition (a) for which the time frame for completion of a standard external review would seriously jeopardize your life or health, or would jeopardize your ability to regain maximum function or (b) that concerns an admission, availability of care, continued stay, or health care item or service for which you received emergency services, but you have not yet been discharged from the facility.

The rules applicable to standard external review, shown above, also apply to expedited external review, subject to the following exceptions:

- **Preliminary Review.** Immediately upon receipt of a request for expedited external review, the Plan will complete its preliminary review and notify you (e.g. telephone, fax) as to whether your request for review meets the preliminary review requirements.
- **Review by an Independent Review Organization (IRO).** After the external review is assigned to the IRO, the Plan will expeditiously (e.g. via telephone, fax, courier, overnight delivery, etc.) provide or transmit to the IRO the documents and information that it considered in making its Adverse Determination. The IRO will provide notice of its decision as expeditiously as your medical condition or circumstances require, but in no event more than **72 hours** after the IRO receives the request for an expedited external review. If the notice of the IRO's decision is not in writing, within 48 hours after the date of providing that notice, the IRO must provide written confirmation of the decision to you and the Plan.

Claims and Appeals Procedures — Disability Claims

These procedures apply to Claims for benefits under the Plan with respect to an over-age Dependent Child involving a determination by the Plan as to whether or not the Child is disabled and eligible for extended coverage after age 26 (or age 19 for a foster Child or the Child of a Domestic Partner) due to disability (i.e., as a Disabled Dependent Child).

Filing and Processing a Disability Claim

The claims processing rules that apply to Health Claims also apply to the processing of Disability Claims, subject to the following:

A. Disability Claims will be processed within 45 days after the Claim form is filed. This 45-day period may be extended twice, by up to an additional 30 days each time, if an extension is necessary due to matters beyond the control of the Fund. Any notice of an extension will also explain the standards on which entitlement to a benefit is based, the unresolved issues that prevent a decision on the Claim, and the additional information needed to resolve those issues.

B. Any Claim denial notice will include the following additional information: (1) a discussion of the decision, including 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 Plan; (2) a statement that you are entitled to receive, upon request and free of charge, reasonable access to and copies of all documents, records, and other information relevant to your Claim; (3) the internal rule, guideline, protocol, standard, or similar criterion of the Plan relied upon in making the adverse determination or, alternatively, a statement that such information does not exist.

Appeal of a Disability Claim Denial

The appeals processing rules that apply to Health Claims also apply to the processing of appeals of Disability Claims, subject to the following:

Any appeal denial notice will include the following additional information:

A. A discussion of the decision, including 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 Plan;

B. A description of any applicable contractual limitations period that applies to the Claimant's right to bring an action under ERISA section 502(a), and the calendar date on which the limitations period expires; and

C. The internal rule, guideline, protocol, standard, or similar criterion of the Plan relied upon in making the adverse determination or, alternatively, a statement that such information does not exist.

This concludes the claims and appeals procedures with respect to Disability Claims under this Plan. This Plan does not offer an additional voluntary appeal process for Disability Claims.

Claims and Appeals Procedures — Non-Health Claims

These claims and appeals procedures apply to Non-Health Claims, which are Claims for Death, Accidental Death & Dismemberment, and Industry Vacation Benefits.

Filing a Non-Health Claim

Claims must be filed in writing with the Fund Office on a form acceptable to the Board of Trustees.

- Claims for Death Benefits must be filed within one year after the date of death.
- Claims for Accidental Death & Dismemberment Benefits must be filed within one year after the date of death or loss.
- Usually, you do not have to file a Claim for Industry Vacation Benefits. However, if you question the amount of Industry Vacation Benefits paid by your Employer, you may file a Claim with the Fund Office within one year from when payment was due or issued.

A Claim is considered filed on the date it is received by the Fund at its principal office (or on the date postmarked, if mailed to the Fund through the U.S. Postal Service), regardless of whether it contains all the information necessary to render a decision. **Claims filed after these deadlines will be denied.**

Processing a Non-Health Claim

A Claim will be processed within 90 days after it is filed. This 90-day period may be extended by up to an additional 90 days if special circumstances require an extension of time. You will be notified of an extension before it is taken, the reason for the extension, and the date a decision is expected. You may voluntarily agree to extend the time for the Fund to process your Claim.

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 the 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. Contains a statement that you are entitled to receive upon request, free access to and copies of documents relevant to your Claim.

F. States the Claimant's right to bring a civil action under ERISA Section 502(a) following the denial of a Claim on appeal.

Filing an Appeal of a Non-Health Claim Denial

You may file an appeal if your Claim is denied, in whole or in part. The appeal must be in writing and include your name, mailing address, telephone number, and the basis of the appeal. You may submit written comments, documents, records, evidence, testimony, and other information relating to the Claim to support your appeal.

The Fund will provide you, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant to your Claim.

An appeal must be filed with the Fund within 60 days after you receive the written denial notice. The appeal is considered filed on the date it is received by the Fund at its principal office (or on the date postmarked, if mailed to the Fund 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.

Processing an Appeal of a Non-Health Claim Denial

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 that relates to the 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 shall 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 shall 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 an 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 notified of an extension before it is taken, the reason for the extension, and the date a decision is expected. If asked to submit information necessary to decide the 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 from the date of the extension notice until the earlier of the date you respond or the due date set by the Fund. You may voluntarily agree to extend the time for the Fund to process your appeal. You will be provided with a written notice of the decision within five days after the Committee or Board makes its decision.

If your Claim is denied on appeal, you will receive a 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 the Claimant's right to bring an action under ERISA Section 502(a).

This concludes the claims and appeals procedures with respect to Non-Health Claims under this Plan. This Plan does not offer an additional voluntary appeal process for Non-Health Claims.

Additional Rules Applicable to All Claims and Appeals

Exhaustion of the Plan's Internal Claims and Appeals Procedures

A Participant or other Claimant must first exhaust the Plan's internal claims and appeals process before filing a civil action under ERISA Section 502(a) against the Plan or the Board of Trustees. This means that before you may take legal action, you must follow all of the applicable procedures for filing an internal claim and an appeal as described in this document.

There are certain exceptions to the requirement to exhaust the Plan's internal claims and appeals procedures. First, for Non-Health Claims, you may take legal action without first exhausting the Plan's internal claims and appeals procedures if the Plan fails to substantially comply with the claims and appeals procedures that apply to Non-Health Claims, and it does not correct the error without prejudice to you.

Second, for Health Claims or Disability Claims, you may take legal action without first exhausting the Plan's internal claims and appeals procedures if the Plan fails to comply with the claims and appeals procedures for Health Claims or Disability Claims, whichever applies. This exception, however, does not apply if the Plan's failure is minor and (1) does not prejudice you, (2) is not attributable to good cause or matters beyond the Plan's control, (3) occurs in the context of a good faith exchange of information between you and the Plan, and (4) 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 Plan, and the Plan will respond to your request, within 10 days, 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.

Limitation on When a Lawsuit May Be Filed

A Participant or other Claimant may not commence a lawsuit or other legal action to obtain Plan benefits **until after all administrative procedures have been exhausted (including the exhaustion or deemed exhaustion of this Plan's claims and appeals procedures), for every issue relevant to a Claim for benefits under the Plan**. However, you are not required to exhaust the Plan's external review process before seeking a judicial remedy.

No lawsuit may be filed (started) more than three years after the end of the year in which services were provided (or more than three years after the start of the disability in the case of a Disability Claim).

Discretionary Authority of Plan Administrator and Designees

The Board of Trustees or, as applicable, the Appeals Committee, has full discretionary authority to interpret the Plan and to construe and apply the terms of the Plan and all rules relating thereto; to determine eligibility and entitlement to benefits under the Plan, and to decide in its sole discretion all issues arising in connection therewith, in accordance with the terms of the Plan.

The determinations of the Board of Trustees or, as applicable, the Appeals Committee, will be conclusive and binding upon all persons and for all purposes.

Any review of a final decision or action of the Board of Trustees or the Appeals Committee shall be based only on such evidence presented to or considered by the Board or Committee, as applicable, at the time it made the decision that is the subject of review. 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.

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 Plan may, at its discretion, pay Plan Benefits directly to the Health Care Professional(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 Plan's obligations to the extent of that payment. Neither the Plan, the Board of Trustees, an Appropriate Claims Administrator, nor any other designee of the Plan Administrator will be required to see to the application of the money so paid.

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 coverage under the Plan (including COBRA coverage).

If your eligibility or enrollment request is denied, you may file an appeal. 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 at its principal office (or on the date postmarked, if mailed to the Fund 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 shall 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 shall 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 an 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 Committee or Board makes its decision.

Workers' Compensation

In this section of the SPD, titled Workers' Compensation, the term "you" and "your" apply to all Participants covered under the Plan.

This Plan **does not provide** benefits if the expenses are covered by workers' compensation or occupational disease law.

Under the terms of the Plan, benefits are not payable for any loss caused by or resulting from any employment, including self-employment. If you incur such a loss, you should file a Workers' Compensation claim with your employer.

In the event that your employer denies your claim, you must appeal the denial through your Workers' Compensation Carrier. The Appeals Board will then issue an Application for Adjudication.

In order for your claim to be considered for payment under this Fund, you must submit a copy of (1) the denial letter, and (2) the Application for Adjudication to the Fund Office. A notice and request for allowance of Lien will then be issued for your signature for the charges that have been submitted to the Fund Office for medical services rendered as a result of the alleged Workers' Compensation Injury or Illness. Upon receipt of your signed request for allowance of Lien, your pending claims will be processed and the Fund Office will file a Lien claim with the applicable Workers' Compensation program.

Note: No payment will be made for any loss caused by or resulting from any employment, including self-employment, whether or not you, your Spouse or Children are covered by a Workers' Compensation Plan.

THIRD PARTY LIABILITY BENEFITS MUST BE ASSIGNED TO THE FUND, BUT NOT TO EXCEED THE AMOUNT PAYABLE BY THE FUND.

Third Party Liability

The Fund must be reimbursed if you or your Dependents, any heir, estate, representative, or other person (referred to in this Section individually and collectively as "You" or "Your") recover any money from a third party and/or insurance carrier as a result of a lawsuit, settlement, or other award or monetary payment because of a claim they are liable for an Injury, Illness or death for which benefits are payable to You under the terms of the Plan. The Fund shall be entitled to reimbursement beginning with the first dollar

of recovery and in an amount up to, but not exceeding, the full amount it has paid for benefits related to such Injury, Illness or death. The Fund's lien and right to reimbursement has first priority against the entire recovery even if You are not compensated for all your damages and even if the amount of the recovery is attributed to damages other than medical expenses for You. No lien shall apply to any amount received under any uninsured motorist or underinsured motorist coverage in any policy of insurance on which the injured party is a named insured.

Whenever You submit a claim for benefits, You must notify the Fund 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 shall be required to:

- Promptly notify the Fund when a claim or lawsuit is filed by You against a third party or insurance carrier related to any Injury, Illness or death for which benefits are payable under the Plan;
- Sign and execute the Fund's Third Party Reimbursement Agreement and Acknowledgment of the Fund's lien as a precondition to receiving benefits from the Fund. Your failure to sign the agreement and acknowledgment shall not constitute a waiver of the Fund's right to reimbursement;
- Promptly respond to any requests for information from the Fund regarding Your claim or lawsuit; and
- Promptly notify the Fund when a recovery is obtained from any source and reimburse the Fund. This must be done before the recovery is paid to anyone else, including You.

If You fail to comply with the Fund's requirements for securing its reimbursement and lien rights, the Fund has the right to take legal action against You, or to offset all or any portion of its lien for reimbursement against any benefit claims which may be owing at any time to or on behalf of You (regardless of whether You are the person with respect to whose recovery the Fund has lien and reimbursement rights). The Fund may also file notice of its lien and reimbursement rights with any person having a material interest in the existence of the Fund's rights, including but not limited to the court in which any action is filed, the attorney representing You, and the third party responsible for the Injury, Illness or death giving rise to the action for recovery.

The Trustees have the discretion to accept less than the full amount of benefits the Fund has paid in satisfaction of its lien, if they believe it is appropriate under the facts and circumstances. Once the Fund is made aware of Your recovery, you will receive information regarding the amount owed and the Fund's policy and procedures for requesting a reduction or waiver of the amount to be reimbursed to the Fund. Regardless, the Fund shall not make any reduction in its lien if: (1) the Fund becomes involved in any suit or 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 Fund determines that the injured party, or the injured party's attorney, has attempted to evade or avoid the Fund's lien. Evasion and avoidance include, but are not limited to, the failure to advise the Fund that any Injury, Illness or death were caused by a third party, the failure to execute the Fund's Third Party Reimbursement Agreement and Acknowledgment of the Fund's reimbursement and lien rights, or the failure to timely notify the Fund of any recovery. The Fund Office shall have the authority to reduce third-party liens in accordance with the following formula. The Fund will accept the lesser of:

A. Two-thirds of the Fund's lien (100% of the Fund's lien if the Participant obtains a recovery without incurring legal fees); or

B. Fifty percent of the first $25,000 of the individual's net recovery, plus 85% of any excess.

"Net recovery" means the total amount paid or payable to or on behalf of the injured party, less attorney's fees and litigation costs actually expended by or on behalf of the injured party.

The formula set forth above shall not apply to any case where the net recovery exceeds $100,000, but is less than the Fund's lien. Any such case shall be referred to the Appeals Committee of the Board of Trustees to determine the appropriate reduction.

In the event the injured party, or such party's attorney, requests a reduction beyond the formula set forth in A or B above, such request shall be forwarded to the Fund's co-counsel who shall present the same to the Appeals Committee. The Appeals Committee will consider all information submitted by You in determining the appropriateness of any further 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 same on future employment.

General Provisions and Information Required by ERISA

Information Required by ERISA	
Name of Plan	**The United Food & Commercial Workers Unions and Food Employers Benefit Fund** A complete list of the employers sponsoring the Plan may be obtained by Participants upon written request to the Plan Administrator, and is available for examination by Plan Participants.
Employer Identification Number (EIN)	95-2301788
Type of Plan	Employee Welfare Benefits Plan
Plan Number	501
Type of Administration	The Fund's benefits, except for the HMO plans and the Prepaid dental plans, are self-funded and administered by the Board of Trustees with the assistance of a Fund Administrator and staff of the Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds Administration, LLC. Independent HMOs (whose name and address are listed on the Quick Reference Chart in the front of this document) administer the medical HMO Plans and provide payment of claims associated with those benefits. For the Prepaid Dental Plans, the Fund pays individual dental practices a capitation rate for each enrollee.
Plan Administrator	The Board of Trustees is the Plan Administrator.
Name of Plan Sponsor	The Board of Trustees of the United Food & Commercial Workers Unions and Food Employers Benefit Fund.
Address and Telephone Number of the Plan Sponsor	6425 Katella Avenue, Cypress, CA 90630-5238 • 714-220-2297
Agent and Address for Service of Legal Process	The 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: Fund Administrator Southern California United Food & Commercial Workers Unions and Food Employers Joint Benefit Funds Administration, LLC 6425 Katella Avenue, Cypress, CA 90630-5238
Claims Administration	
Fund Office	Claims Administration (and Eligibility determinations) for the Medical PPO Plans, the Indemnity Dental Plan, orthodontic benefits, COBRA Administration and for the self-funded death benefits and the Accidental Death & Dismemberment benefits.
HMC	Utilization Management and pricing for the Mental Health and Substance Abuse Benefits for the Indemnity PPO Medical Plans and the Anthem Blue Cross HMO Plan.
OptumRx	Claims Administration for outpatient Prescription Drug benefits of the Indemnity PPO Medical Plans, the Kaiser HMO Plan and the Anthem Blue Cross HMO Plan.
Kaiser Permanente HMO	Claims Administration for the insured Kaiser HMO Medical Plan
Anthem HMO	Claims Administration for the insured Anthem Blue Cross HMO Medical Plan
• Dr. Schnierow and Associates **• Ilya Zak, D.D.S.** **• Allcare Dental** **• San Diego Dental Group** **• Santa Monica Dental Practice**	Claims Administration for the Prepaid Dental Plans

Trustees of the Plan	
Employer Trustees	**Union Trustees**
Brent Bohn Albertsons, Inc. 1421 S. Manhattan Avenue (mail drop U523) Fullerton, CA 92831	**Greg Conger** UFCW Local 324 8530 Stanton Avenue Buena Park, CA 90620
Frank Jorgensen Safeway, Inc. P.O. Box 85001 Bellevue, WA 98105-8501	**Joe Duffle** UFCW Local 1167 855 West San Bernardino Bloomington, CA 92316
Duane Snider Stater Bros. Markets 301 South Tippecanoe Avenue San Bernardino, CA 92408	**Kathy Finn** UFCW Local 770 630 Shatto Place Los Angeles, CA 90005
Leroy Westmoreland Ralphs Grocery Company 1100 West Artesia Boulevard Compton, CA 90220	**Mark Ramos** UFCW Local 1428 705 West Arrow Highway Claremont, CA 91711
	Michael Straeter UFCW Local 1442 9075 La Cienega Blvd. Inglewood, CA 90301
	Todd Walters UFCW Local 135 2001 Camino Del Rio South San Diego, CA 92108

Plan's Requirements for Eligibility and Benefits

The Plan's requirements with respect to eligibility as well as circumstances that may result in disqualification, ineligibility or denial or loss of benefits are described in the Eligibility chapter and in the remaining chapters that describe Plan benefits.

Collective Bargaining Agreements

The Plan is maintained in accordance with Collective Bargaining Agreements between various Employers and Union Locals of the United Food & Commercial Workers International Union. Any Participant or beneficiary may, upon written request to the Plan Administrator, obtain information as to whether or not a particular Union or employer is a party to the Plan and, if so, its address. Copies of the applicable Collective Bargaining Agreement are available for examination at the Fund Office or at the office of your Union Local.

Funding Medium

Benefits are provided from the Fund's assets which are accumulated under the provisions of the Collective Bargaining Agreement 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 Benefit Fund.

Contribution Source

All contributions to the Plan are made by Employers and Employees in accordance with Collective Bargaining Agreements and participation agreements between the Fund and participating Employers. The Collective Bargaining and participation agreements require contributions to the Plan at a fixed rate per hour worked or paid. The Fund Office will provide you, upon written request, information as to whether a particular employer is contributing to this Plan on behalf of Eligible Employees working under a Collective Bargaining Agreement.

Plan Year

The Plan's fiscal records are kept on a 12-month basis beginning on April 1 and ending on March 31.

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.

Statement of ERISA Rights

As a Participant in the United Food & Commercial Workers Unions and Food Employers 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 at other specified locations, such as worksites and Union halls all documents governing the Plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.
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 COBRA chapter. You and/or your Dependents may have to pay for such coverage, if it is elected. Review this Summary Plan Description and the documents governing the Plan on the rules governing your COBRA Continuation Coverage rights.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for Plan Participants, ERISA imposes duties upon the people who are responsible for the operation of the employee benefit plan. The people who operate your plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan Participants and beneficiaries.

No one, including your Employer, your Union, or any other person may fire you or otherwise discriminate against you in any way to prevent you from obtaining a welfare benefit or exercising 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 Filing and Appeals Information 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 (formerly known as the Pension and Welfare Benefit 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 (formerly known as the Pension and Welfare Benefit Administration) toll-free at 866-444-EBSA (3272).

Plan Amendments or Termination of Plan

This Health Care Plan will remain in effect as long as there are Employers who are obligated under any Collective Bargaining Agreement to make contributions. 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 anytime.

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 this Plan should not be interpreted as a guarantee of employment.

B. The Board of Trustees, as the Plan Sponsor, intends that the terms of this Plan described in this document, including those relating to coverage and benefits, be legally enforceable, and that each plan is maintained for the exclusive benefit of Participants, as defined by law.

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 chapter **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 Participant, who is Totally Disabled or who has submitted a claim for benefits and is undergoing treatment under the care of a Physician, be examined by a Physician selected by the Plan Administrator or its designee at any time during the period that benefits are extended under this Plan. The cost of such an examination will be paid by the Plan.

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 this Plan, you or your covered Dependents must furnish information you or they may have that may affect eligibility for coverage under the Plan.

Failure to give this Plan a timely notice (as noted above) may cause your Spouse and/or Dependent Child(ren) to lose their right to obtain COBRA Continuation Coverage, or may cause the coverage of a Dependent Child to end when it otherwise might continue because of a disability, or may cause claims to not be able to be considered for payment until eligibility issues have been resolved, or may result in a participant's liability to the Plan if any benefits are provided to an ineligible person.

Notice Regarding Wellness Program

The My Health/My Choices Incentive Program and the Disease Management Program, collectively referred to in this notice as the "Wellness Program," is a voluntary wellness program available to all Employees. The Wellness Program is administered according to federal rules permitting employer-sponsored wellness programs that seek to improve employee health or prevent disease, including the Americans with Disabilities Act of 1990, the Genetic Information Nondiscrimination Act of 2008, and the Health Insurance Portability and Accountability Act, as applicable, among others. If you choose to participate in the Wellness Program, you may be asked to complete a voluntary health risk questionnaire or "HRQ" that asks a series of questions about your health-related activities and behaviors and whether you have or had certain medical conditions (e.g., cancer, diabetes, or heart disease). You are not required to complete the HRQ or to participate in the Wellness Program.

However, Employees who choose to participate in the Wellness Program will receive incentives, including HRA contributions and lower priced drugs under the Disease Management Program. Additional incentives may be available for Employees who participate in certain health-related activities (see activities and rewards outlined beginning on page 21). If you think you might be unable to participate in any of the health-related activities or achieve any of the health outcomes required to earn an incentive. due to a physical disability or medical condition, you may be entitled to a reasonable accommodation or an alternative standard, which will give you the opportunity to earn the same incentive by different means. You may request a

reasonable accommodation or an alternative standard by contacting the Trust Fund Office. We will work with you (and, if you wish, with your doctor) to find a reasonable alternative standard with the same incentive that is right for you in light of your health status.

The information from your HRQ and the results from any physical exam or biometric screening will be used to provide you with information to help you understand your current health and potential risks, and may also be used to offer you services through the Wellness Program, such as a tobacco cessation program. You also are encouraged to share your results or concerns with your own doctor.

Protections from Disclosure of Medical Information

We are required by law to maintain the privacy and security of your personally identifiable health information. Although the Wellness Program and the Fund may use aggregate information it collects to design a program based on identified health risks in the workplace, we will never disclose any of your personal information either publicly or to the Trustees, your Employer, or your Union, except as necessary to respond to a request from you for a reasonable accommodation needed to participate in the Wellness Program, or as expressly permitted by law. Medical information that personally identifies you that is provided in connection with the Wellness Program will not be provided to your supervisors or managers and may never be used to make decisions regarding your employment.

Your health information will not be sold, exchanged, transferred, or otherwise disclosed except to the extent permitted by law to carry out specific activities related to the Wellness Program, and you will not be asked or required to waive the confidentiality of your health information as a condition of participating in the Wellness Program or receiving an incentive. Anyone who receives your information for purposes of providing you services as part of the Wellness Program will abide by the same confidentiality requirements. The only individual(s) who will receive your personally identifiable health information is (are) a registered nurse, a doctor, or a health coach in order to provide you with services under the Wellness Program.

In addition, all medical information obtained through the Wellness Program will be maintained separate from your personnel records, information stored electronically will be encrypted, and no information you provide as part of the Wellness Program will be used in making any employment decision. Appropriate precautions will be taken to avoid any data breach, and in the event a data breach occurs involving information you provide in connection with the Wellness Program, we will notify you immediately.

You may not be discriminated against in employment because of the medical information you provide as part of participating in the Wellness Program, nor may you be subjected to retaliation if you choose not to participate.

If you have questions or concerns regarding this notice, or about protections against discrimination and retaliation, please contact the Trust Fund Office.

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 United Food & Commercial Workers Unions and Food Employers
Joint Benefit Funds Administration, LLC
6425 Katella Avenue
Cypress, California 90630
Phone: 714-220-2297 ext. 380
Fax: 714-220-2002

General Statement of Nondiscrimination

United Food & Commercial Workers Unions and Food Employers Benefit Fund

Health and Human Services (HHS) Non-discrimination Notice

The UFCW Unions and Food Employers Benefit Fund (the "Plan") does not discriminate with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability or sex. The Plan provides free aids and services (such as qualified interpreters and information in alternative formats) when necessary to ensure equal opportunity for individuals with disabilities, and free language assistance services (such as translated documents and oral interpretation) when necessary to provide meaningful access to individuals with limited English proficiency. If you need these services, contact the Plan's Civil Rights Coordinator at:

Mail: United Food & Commercial Workers Unions and Food Employers Benefit Fund
6425 Katella Avenue
Cypress, CA 90630
Attention: Civil Rights Coordinator

Phone: 714-220-2297, 562-408-2715, or 877-284-2320 (ask for the Civil Rights Coordinator)

Fax: 714-220-2002 (Attention: Civil Rights Coordinator)

If you believe that the Plan has failed to provide these services or has otherwise discriminated on the basis of race, color, national origin, sex, age, or disability, you may file a written grievance with the Fund's Civil Rights Coordinator as soon as possible at the address listed above. If you need help filing a grievance, the Civil Rights Coordinator can help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 800-368-1019, 800-537-7697 (TDD). Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html.

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم 2320-284-877

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 877-284-2320.

ATTENTION: Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le 877-284-2320.

ATANSYON: Si w pale Kreyòl Ayisyen, gen sèvis èd pou lang ki disponib gratis pou ou. Rele 877-284-2320.

General Statement of Nondiscrimination (continued)

ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: 877-284-2320.

ATTENZIONE: In caso la lingua parlata sia l'italiano, sono disponibili servizi di assistenza linguistica gratuiti. Chiamare il numero 877-284-2320.

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。877-284-2320 まで、お電話にてご連絡ください。

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 877-284-2320 번으로 전화해 주십시오.

توجه :اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد .با 877-284-2320 تماس بگیرید.

UWAGA: Jeżeli mówisz po polsku, możesz skorzystać z bezpłatnej pomocy językowej. Zadzwoń pod numer 877-284-2320.

ATENÇÃO: Se fala português, encontram-se disponíveis serviços linguísticos, grátis. Ligue para 877-284-2320.

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните 877-284-2320.

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al 877-284-2320.

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa 877-284-2320.

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số 877-284-2320.

Definitions

The following are definitions of specific terms and words used in this document or that would be helpful in understanding covered or excluded health care services. These definitions do not, and should not be interpreted to, extend coverage under the Plan.

Allowed Amount: The amount this Plan allows for eligible Medically Necessary services or supplies. This allowance is subject to applicable copays, coinsurance and deductibles. The Allowed Amount, as determined by the Plan Administrator or its Designee, is the **lower** of the Health Care Provider's actual billed charge or:

A. For a PPO Provider, the negotiated fee/rate set forth in the contract between the in-network Health Care Provider and the PPO network or the Plan Administrator or its Designee.

B. Notwithstanding paragraph A, the maximum Allowed Amount for a routine total hip and/or knee replacement surgery in a Hospital facility in the state of California, is $30,000. (Any such surgery outside the state of California will be subject to normal surgery benefits).

C. For a Non-PPO provider, the Allowed Amount means the dollar amount the Fund has determined it will allow for the Medically Necessary service or supply.

The Fund rarely pays benefits equal to or based on the Health Care Provider's actual billed charges for health care services or supplies, even after you have paid the applicable Deductible, Copay and/or Coinsurance. This is because the Fund covers only the "Allowed Amount" for health care services or supplies.

Any charge in excess of the "Allowed Amount" does not count toward the Plan's annual Medical or Prescription Drug Out-of-Pocket Maximums. Participants are responsible for charges that exceed the Plan's "Allowed Amount."

Ambulatory Surgery Facility (Sometimes referred to as Ambulatory Surgery Center or Outpatient Surgery Center): A specialized facility that is established, equipped, operated and staffed primarily for the purpose of performing outpatient surgical procedures and which fully 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:
   - 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.
   - 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.
   - Provides at least one operating room and at least one post-anesthesia recovery room.
   - Is equipped to perform diagnostic x-ray and laboratory examinations or has an arrangement to obtain these services.
   - Has trained personnel and necessary equipment to handle emergency situations.
   - Has immediate access to a blood bank or blood supplies.
   - 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.
   - 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 Billing: A bill from a Health Care Provider to a patient for the difference (or balance) between this Plan's Allowed Amount and what the provider actually charged (the billed charges). Amounts associated with Balance Billing **are not covered** by this Plan. **Generally, you can avoid Balance Billing by using PPO Providers.**

Behavioral Health Disorder: Behavioral Health is an umbrella term that refers to mental health and/or substance abuse/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 or psychiatric drugs or medications regardless of any underlying physical or organic cause.

Calendar Year: The 12-month period beginning January 1 and ending December 31.

Chemical Dependency: This is another term for substance abuse/substance use disorder.

Child or Children: This term refers to a Covered Employee's Dependents other than the Employee's Spouse or Domestic Partner.

Collective Bargaining Agreement: The current Retail Food, Meat, Bakery, Candy, and General Merchandise Agreement and any other agreement approved by the Board of Trustees which provides for contributions to this Fund in accordance with the provisions of the Trust Agreement, at the contribution rate for Plan A benefits.

Cosmetic Surgery or Treatment: Surgery or medical treatment to improve or preserve physical 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.

Covered Employee: A person who is employed by a contributing Employer and who is eligible for and has coverage under Plan A of the Fund.

Covered Employment: Employment within the jurisdiction of the Union with an Employer that is required to contribute to the Fund on behalf of the Employee, pursuant to an applicable Collective Bargaining Agreement. Covered Employment includes employment by the Union and the Southern California United Food & Commercial Workers Unions and Food Employers Joint Funds Administration, LLC, for which contributions to the Fund are required.

Custodial Care/Custodial Services: Care and/or services that are provided to help a person to perform activities of daily living, including personal hygiene. Custodial Services include personal care, homemaking services, moving the patient, acting as companion or sitter, or supervising medication which can usually be self-administered. Such services will be considered custodial regardless of who recommends, orders, provides or directs the care or the location for the care.

Dependents

Dependents eligible for the Fund's health care coverage are:

- Your legally married Spouse (does not apply to Clerk's Helpers)
- Your Domestic Partner with whom you have a Certificate of Registration of Domestic Partnership filed with the California Secretary of State (does not apply to Clerk's Helpers)
- Your child(ren) under age 26, if they are your:
  - Natural child;
  - Legally adopted child (or child placed with you for adoption);
  - Stepchild; or
  - Child covered as a result of a QMCSO or National Medical Support Notice.
- Your Domestic Partner's child(ren) who meet all of the following criteria:
  - They are unmarried;
  - They are dependent on you for support; and
  - They are (a) under age 19, or (b) under age 24 and a full-time student at an accredited educational institution.
- A foster child:
  - Placed by a government agency or court order, under age 26; or
  - A foster child not placed by a government agency or court order whose status is established by a Natural Parents' Certification, and who meets the requirements outlined in the Fund's *Application for Coverage of a Foster Child as an Eligible Dependent* form.

- An "over-age" disabled Child who is unmarried, unemployable and totally dependent on you for support (as described in the Eligibility for Disabled Dependent Children application form) because of a permanent mental or physical disability, including:
  - Your natural Child, legally adopted Child, or stepchild. Coverage may be provided to the Child over age 25 if his or her disability began prior to age 26.
  - Your domestic partner's Child. Coverage may be provided to the Child over age 18 if his or her disability began prior to: (a) age 19, or (b) between the ages of 19 and 24 while covered as a Dependent and a full-time student at an accredited educational institution.
  - A foster Child placed by a government agency or court order. Coverage may be provided to the Child over age 25 if his or her disability began prior to age 26 or as required by applicable law.
  - A foster Child that is not placed by a government agency or court order who is dependent on you for support. Coverage may be provided to the foster Child over age 18 if his or her disability began prior to: (a) age 19, or (b) between the ages of 19 and 24 while covered as a Dependent and a full-time student at an accredited educational institution.

Dependent Child: A Dependent who is not a Spouse or Domestic Partner.

Domestic Partner: A person with whom you have a Certificate of Registration of Domestic Partnership filed with the California Secretary of State.

Dual Coverage: Coverage under the Benefit Fund both as a Covered Employee and as the Dependent of another Covered Employee (this may occur when two family members are eligible for Fund benefits). In order to have Dual Coverage, both covered Employees must elect family coverage.

Durable Medical Equipment: Equipment that can withstand repeated use; and is primarily and customarily used for a medical purpose and is not generally useful in the absence of an Injury or Illness; and 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, commodes, electric Hospital beds with safety rails, electric and manual wheelchairs, nebulizers, oximeters, oxygen and supplies, and ventilators.

Eligible Medical Expense: Eligible Medical Expenses are limited to expenses for medical services and supplies that are:

1. **"Medically Necessary,"** but only to the extent that the charges do not exceed the "Allowed Amounts" (as defined above);
2. **Not excluded from coverage** (as provided in the Excluded Services and Limitations section of this document);
3. **Not in excess of a maximum plan benefit** as shown in the Schedule of Medical Benefits; and
4. **For the diagnosis or treatment of an Injury or Illness** (except where wellness/preventive services are payable or if specifically covered under the Plan, as noted in the Schedule of Medical Benefits in this document).

Emergency Care: Medical care and treatment provided after the sudden 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 manifesting itself by acute symptoms of sufficient severity (including severe pain) so that a prudent layperson who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in serious jeopardy to the health of the individual (or for a pregnant woman, the health of the woman or her unborn Child), serious impairment to bodily functions or serious dysfunction of any bodily organ or part.

Emergency Services: With respect to an Emergency Medical Condition (defined above), a medical screening examination **within the emergency department of a Hospita**l including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition, along with additional medical examination and treatment to stabilize the patient.

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

Employee: Unless specifically indicated otherwise, when used in this document, Employee refers to a person employed under a Collective Bargaining Agreement and on whose account the Employer is obligated to make, and is making, required contributions to this Plan.

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:

A. 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;

B. 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

C. 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.

Fund/Benefit Fund/Plan: The United Food & Commercial Workers Unions and Food Employers Benefit Fund.

Health Care Practitioner: A provider 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'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.

Health Care Provider or Provider: A Health Care Practitioner as defined above, or a licensed health care facility (some examples include Hospital, Ambulatory Surgery Facility/Center, Birthing Center, Home Health Care Agency, Hospice, Skilled Nursing Facility, or Subacute Care Facility/Long Term Acute Care facility) licensed, certified, or accredited in accordance with the requirements of state law.

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:
   - 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.
   - Has a full-time administrator.
   - Is run according to rules established by a group of professional Health Care Providers including Physicians and RNs.
   - Maintains written clinical records of services provided to all patients.
   - Its staff includes at least one RN or it has nursing care by an RN available.
   - Its Employees are bonded.
   - Maintains malpractice insurance coverage.

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. A Hospice Facility means 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. A Hospice is 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.

Hospital: A class of health care institutions 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 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 to be an Illness only for the purpose of coverage under this Plan. However, infertility is not an Illness for the purpose of coverage under this Plan.

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 medical practitioner, 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:

- In accordance with generally accepted standards of medical practice; and
- Clinically appropriate in terms of type, frequency, extent, site and duration and considered effective for the patient's Illness, Injury or disease; and
- Not primarily for the convenience of the patient, Physician or other Health Care Provider; and
- Not experimental, educational or unproven (investigational); and
- 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.

Natural Parents Certification: A child who does not meet the Internal Revenue Code definition of a foster child may still be covered as a foster child if he or she qualifies under the Natural Parent certification. In order to qualify as a foster child under the Natural Parent Certification, the child must:

- Be less than 19 years of age and unmarried;
- Be totally dependent on you for support and maintenance: the child's other sources of income cannot exceed $2,500 annually, except from Social Security and/or other public aid, and you claim the child as a dependent on your federal and state income tax returns;
- Reside with you on a permanent basis; and
- Meet one of the following criteria:
  - One or both natural parents of the child, if living, must give you authority to exercise parental control and responsibility as though the child were your natural child.
  - If one or both of the child's natural parents reside with you, the parent(s) must be under age 18, unmarried and totally dependent upon you for support and maintenance. If a natural parent residing with you reaches age 18 or marries, the foster child will no longer qualify for benefit coverage under the Fund.

In addition, in order to continue a foster child's coverage after he or she becomes 19 years of age, the child must have been covered for at least five years prior to the date he or she becomes age 19.

Non-PPO: A Health Care Provider who **does not participate** in the Plan's network of providers (is not a PPO Provider). Also referred to as Out-of-Network or Non-Network.

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 offered by the Plan. Open Enrollment is generally held in the fall with enrollment changes effective the following January 1st.

Orthopedic (Appliance or Device): A type of Corrective Appliance or device, either customized or available "over-the-counter," designed to support a weakened body part, including, but not limited to, crutches, specially designed corsets, foot orthotics (subject to dollar limit), leg braces, extremity splints, and walkers. For the purposes of the Medical Plan, this definition does not include dental orthotics.

Out-of-Area: The out-of-area level of benefits will apply if there are no PPO/Blue Card Providers available to provide the requested Medically Necessary service within 40 miles of your home.

Participant: Any person eligible for benefits under the Plan, whether as an Employee or as the Dependent of an Employee, who has completed all required formalities for enrollment and coverage under the Plan, and is actually covered by the Plan.

Physical Therapy: Rehabilitation directed at restoring function following disease, Injury, surgery or loss of body part using therapeutic properties such as active and passive exercise, cold, heat, electricity, traction, diathermy, and/or ultrasound to improve circulation, strengthen muscles, return motion, and/or train/retrain an individual to perform certain activities of daily living such as walking and getting in and out of bed.

Physician: A person legally licensed as a Medical Doctor (MD) or Doctor of Osteopathy (DO) or Doctor of Podiatric Medicine (DPM) and authorized to practice medicine, to perform surgery, and to administer drugs, under the laws of the state or jurisdiction where the services are rendered who acts within the scope of his or her license and is not the patient.

Podiatrist: A person legally licensed as a Doctor of Podiatric Medicine (DPM) who acts within the scope of his or her license and who 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.

PPO: Preferred Provider Organization. A PPO is an organization that has contracted with Health Care 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. These Health Care Providers are called "PPO Providers" or "Network Providers."

Precertification or Preauthorization: A review performed by Anthem, OptumRx, the Fund Office or HMC before services are rendered, to determine that the service, admission and/or length of stay in a healthcare 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 and at least one of them is a Federal Legend Drug or a drug that requires a prescription under state law. Some compound drugs are only available at a retail pharmacy location, not mail order.

3. **Brand Drug:** Any drug that has been approved by the U.S. Food and Drug Administration (FDA) and that drug has been granted a 20-year patent, which means that no other company can make it for the entire duration of the patent period. This patent protection means that only the company who holds the patent has the right to sell that brand drug. A brand drug cannot have competition from a generic drug until after the brand-name patent or other marketing exclusivities have expired and the FDA grants approval for a generic version.
4. **Generic Drug:** Any generic version of a brand-name drug (basically a 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 work in the same way and in the same amount of time as brand-name drugs. The generic drug must be the same (or bio-equivalent) in several respects: the active ingredients (those ingredients that are responsible for the drug's effects), the dosage amount, the way in which the drug is taken must be the same as the brand name drug, the safety must be the same and the amount of time the generic drug takes to be absorbed into the body must be the same as the brand name drug. A generic drug has been approved by the U.S. Food and Drug Administration (FDA). Generic drugs can have different names, shapes, colors and inactive ingredients than the original brand name drug.

Prosthetic Appliance (or Device): A type of Corrective Appliance or device designed to replace all or part of a missing body part, including, but not limited to, artificial limbs and eyes or a heart pacemaker.

Qualified Medical Child Support Order (QMCSO): Please refer to the description beginning on page 13 for a description of what constitutes a QMCSO.

Rescission: 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 Plan 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.

Required Hours: The hours you must work in Covered Employment each month to earn or continue eligibility for benefits under the Fund.

Skilled Nursing Facility (SNF): A public or private facility, licensed and operated according to law, that primarily provides skilled nursing and related services to people who require medical or nursing care and that rehabilitates injured, disabled or sick people, and that meets ***all*** of 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 licensed Registered Nurse 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 in this document, will be considered a Skilled Nursing Facility for the purposes of this Plan.

Speech Therapy: Rehabilitation directed at treating defects and disorders of spoken and written communication to restore normal speech or to correct dysphagic or swallowing defects and disorders **lost** due to Illness or Injury.

Spouse: An Employee's Spouse is the individual who is legally married to the Employee, as recognized under the laws of the state or jurisdiction in which the marriage was entered into.

Union or Union Local: Any one of the United Food & Commercial Workers Union Locals 8, 135, 324, 770, 1167, 1428 or 1442.

You, Your: When used in this document, these words refer to the Employee who is covered by the Plan. They do ***not*** refer to any Dependent of the Employee, unless specifically stated otherwise.

Appendix A — Chiropractic/Spinal Manipulation/Acupuncture Schedule of Allowances — All Providers

CPT Codes	Allowance	Description
97780*	$52.50	2004 acupuncture — per session
97781*	$52.50	2004 acupuncture — per session
97810	$17.50	2005 acupuncture — initial 15 min.
97811	$17.50	2005 acupuncture — each additional 15 min.
97813	$17.50	2005 acupuncture — initial 15 min.
97814	$17.50	2005 acupuncture — each additional 15 min.
98940	$25.94	chiro manipulation
98941	$25.94	chiro manipulation
98942	$25.94	chiro manipulation
98943	$25.94	chiro manipulation
99201	$31.50	chiro office visit — new patient
99202	$31.50	spinal manipulation office visit — new patient
99203	$31.50	spinal manipulation office visit — new patient
99204	$31.50	spinal manipulation office visit — new patient
99212	$25.94	spinal manipulation office visit — established patient
99213	$25.94	spinal manipulation office visit — established patient
99214	$25.94	spinal manipulation office visit — established patient
97012	$9.98	therapeutic modality
97014	$9.98	therapeutic modality
97016	$9.98	therapeutic modality
97018	$9.98	therapeutic modality
97020	$9.98	therapeutic modality
97022	$9.98	therapeutic modality
97024	$9.98	therapeutic modality
97026	$9.98	therapeutic modality
97028	$9.98	therapeutic modality
97032	$9.98	therapeutic modality
97033	$9.98	therapeutic modality
97034	$9.98	therapeutic modality
97035	$9.98	therapeutic modality
97036	$9.98	therapeutic modality
97039	$9.98	therapeutic modality
97110	$9.98	therapeutic modality
97112	$9.98	therapeutic modality
97113	$9.98	therapeutic modality
97116	$9.98	therapeutic modality
97124	$9.98	therapeutic modality
97139	$9.98	therapeutic modality
97140	$9.98	therapeutic modality
71010	$27.93	x-ray, chest
71020	$42.98	x-ray, chest
71021	$48.88	x-ray, chest
71030	$54.86	x-ray, chest

CPT Codes	Allowance	Description
71100	$48.88	x-ray, ribs
71110	$59.85	x-ray, ribs
71120	$42.89	x-ray, sternum
72010	—	Plan Limitation — not covered
72020	$25.94	x-ray, spine and pelvis
72040	$42.89	x-ray, spine and pelvis
72050	$66.83	x-ray, spine and pelvis
72052	$86.78	x-ray, spine and pelvis
72070	$48.88	x-ray, spine and pelvis
72080	$48.88	x-ray, spine and pelvis
72090	$42.89	x-ray, spine and pelvis
72100	$48.88	x-ray, spine and pelvis
72110	$82.79	x-ray, spine and pelvis
72114	$104.74	x-ray, spine and pelvis
72120	$52.87	x-ray, spine and pelvis
72170	$34.91	x-ray, spine and pelvis
72200	$53.87	x-ray, spine and pelvis
72202	$56.86	x-ray, spine and pelvis
72220	$45.89	x-ray, spine and pelvis
73000	$34.91	x-ray, upper extremities
73010	$42.89	x-ray, upper extremities
73020	$29.93	x-ray, upper extremities
73030	$42.89	x-ray, upper extremities
73050	$48.88	x-ray, upper extremities
73060	$34.91	x-ray, upper extremities
73070	$42.89	x-ray, upper extremities
73080	$42.89	x-ray, upper extremities
73090	$42.89	x-ray, upper extremities
73100	$42.89	x-ray, upper extremities
73120	$29.93	x-ray, upper extremities
73130	$38.90	x-ray, upper extremities
73140	$25.94	x-ray, upper extremities
73500	$34.91	x-ray, lower extremities
73510	$48.88	x-ray, lower extremities
73520	$64.84	x-ray, lower extremities
73550	$42.89	x-ray, lower extremities
73560	$39.62	x-ray, lower extremities
73562	$45.29	x-ray, lower extremities
73564	$44.89	x-ray, lower extremities
73590	$34.91	x-ray, lower extremities
73600	$29.93	x-ray, lower extremities
73610	$39.90	x-ray, lower extremities
73620	$27.93	x-ray, lower extremities
73630	$37.91	x-ray, lower extremities
73650	$29.93	x-ray, lower extremities
73660	$25.94	x-ray, lower extremities

Appendix B — Mandatory Anthem Blue Cross Notice

Out of Area Programs

Benefits will be provided for covered services received outside of California within the United States, Puerto Rico, and U.S. Virgin Islands. The Fund calculates the Participant's cost sharing as a percentage of the Allowable Amount or a dollar copay, as defined in this SPD. When covered services are received in another state, the Participant's copay will be based on the local Blue Cross and/or Anthem Blue Cross plan's arrangement with its providers. See the BlueCard Program section in this SPD.

Anthem Blue Cross of California has a variety of relationships with other Blue Cross and/or Anthem Blue Cross plans and their Licensed Controlled Affiliates ("Licensees") referred to generally as "Inter-Plan Programs." Whenever you obtain healthcare services outside of California, the claims for these services may be processed through one of these Inter-Plan Programs, which includes the BlueCard Program.

When you access covered services outside of California you may obtain care from healthcare providers that have a contractual agreement (i.e., are "participating providers") with the local Blue Cross and/or Anthem Blue Cross Licensee in that other geographic area ("Host Plan"). In some instances, you may obtain care from non-participating healthcare providers. The Fund's payment practices in both instances are described in this SPD.

If you do not see a Participating Provider through the BlueCard Program, you will have to pay for the entire bill for your medical care and submit a claim form to the local Blue Cross and/or Anthem Blue Cross plan or to the Fund for payment. The Fund will notify you of its determination within 30 days after receipt of the claim. The Fund will pay you at the Non-PPO Provider benefit level. Remember, your copay is higher when you see a Non-PPO Provider. You will be responsible for paying the entire difference between the amount paid by the Fund and the amount billed.

Charges for services which are not covered, and charges by Non-PPO Providers in excess of the amount covered by the Plan, are the Participant's responsibility and are not included in copay calculations.

When you require covered services while traveling outside of California:

1. Call **BlueCard Access**® at 800-810-BLUE (2583) to locate Physicians and Hospitals that participate with the local Blue Cross and/or Anthem Blue Cross plan, or go on-line at **www.bcbs.com** and select the "Find a Doctor or Hospital" tab; and
2. Visit the Participating Physician or Hospital and present your membership card.

The Participating Physician or Hospital will verify your eligibility and coverage information by calling **BlueCard Eligibility** at 800-676-BLUE (2583). Once verified and after services are provided, a claim is submitted electronically and the Participating Physician or Hospital is paid directly. You may be asked to pay for your applicable copay and Plan deductible at the time you receive the service.

You will receive an explanation of benefits which will show your payment responsibility. You are responsible for the copay and Plan deductible amounts shown in the explanation of benefits.

Prior authorization is required for all inpatient Hospital services and notification is required for inpatient Emergency Services. Prior authorization is required for selected inpatient and outpatient services, supplies and durable medical equipment. To receive prior authorization from the Fund, the out-of-area provider should call the customer service number noted on the back of your identification card.

If you need Emergency Services, you should seek immediate care from the nearest medical facility. The benefits of this Plan will be provided for covered services received anywhere in the world for Emergency Care of an illness or injury.

Care for Covered Urgent Care and Emergency Services Outside the United States

Benefits will also be provided for covered urgent and emergent services received outside of the United States, Puerto Rico, and U.S. Virgin Islands. If you need urgent care while out of the country, call the BlueCard Worldwide Service Center at either the toll-free BlueCard Access number (800-810-2583) or collect (804-673-1177), 24 hours a day, seven days a week. In an emergency, go directly to the nearest hospital. If your coverage requires precertification or prior authorization, you should also call Anthem Blue Cross at the customer service number noted on the back of your identification card. For inpatient hospital care, contact the BlueCard Worldwide Service Center to arrange cashless access. If cashless access is arranged, you are responsible for the usual out-of-pocket expenses (non-covered charges, deductibles, and copays). If cashless access is not arranged, you will have to pay the entire bill for your medical care and submit a claim to the BlueCard Worldwide Service Center.

When you receive services from a physician, you will have to pay the doctor and then submit a claim.

Before traveling abroad, call your local Customer Service office for the most current listing of providers world-wide or you can go on-line at **www.bcbs.com** and select "Find a Doctor or Hospital" and "BlueCard Worldwide."

BlueCard Program

Under the BlueCard® Program, when you obtain covered services within the geographic area served by a Host Plan, the Plan will remain responsible for any payment due, excluding the Participant's liability (e.g., copay and Plan deductible amounts shown in the Benefits SPD. However, the Host Blue is responsible for contracting with and generally handling all interactions with its participating healthcare providers.

The BlueCard Program enables you to obtain covered services outside of California, as defined, from a healthcare provider participating with a Host Plan, where available. The participating healthcare provider will automatically file a claim for the Covered Services provided to you, so there are no claim forms for you to fill out. You will be responsible for the member copay and deductible amounts, if any, as stated in this SPD.

Whenever you access Covered Services outside of California and the claim is processed through the BlueCard Program, the amount you pay for Covered Services, if not a flat dollar copay, is calculated based on the lower of:

1. The billed covered charges for your Covered Services; or
2. The negotiated price that the Host Plan makes available to Anthem Blue Cross of California.

Often, this "negotiated price" will be a simple discount that reflects an actual price that the Host Plan pays to your healthcare provider. Sometimes, it is an estimated price that takes into account special arrangements with your healthcare provider or provider group that may include types of settlements, incentive payments, and/or other credits or charges. Occasionally, it may be an average price, based on a discount that results in expected average savings for similar types of healthcare providers after taking into account the same types of transactions as with an estimated price.

Estimated pricing and average pricing, going forward, also take into account adjustments to correct for over- or underestimation of modifications of past pricing for the types of transaction modifications noted above. However, such adjustments will not affect the price the Fund uses for your claim because they will not be applied retroactively to claims already paid.

Laws in a small number of states may require the Host Plan to add a surcharge to your calculation. If any state laws mandate other liability calculation methods, including a surcharge, we would then calculate your liability for any Covered Services according to applicable law.

Claims for Covered Services are paid based on the Allowable Amount as defined in this SPD.

Special Cases: Value-Based Programs BlueCard® Program

If you receive covered services under a Value-Based Program inside a Host Blue's service area, you will not be responsible for paying any of the Provider Incentives, risk-sharing, and/or Care Coordinator Fees that are a part of such an arrangement, except when a Host Blue passes these fees to Anthem Blue Cross through average pricing or fee schedule adjustments.

Negotiated (Non–BlueCard Program) Arrangements

If Anthem Blue Cross has entered into a Negotiated Arrangement with a Host Blue to provide Value-Based Programs to Employer on your behalf, Anthem Blue Cross will follow the same procedures for Value-Based Programs administration and Care Coordinator Fees as noted above for the BlueCard Program.

Index

H

I

L

M

O

P

Q

S

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U

Southern California United Food & Commercial Workers Unions
and Food Employers Joint Benefit Funds Administration, LLC

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