Health Insurance Plan

TRADESHOW & SIGNCRAFTS
LOCAL UNION
831
Painters and Allied Trades District Council 36
Southern California

Southern California Local 831 - Employer Health Fund
Summary Plan Description
January 1, 2024

Southern California Local Union 831 –
Employer Health Fund
Summary Plan Description
Effective January 1, 2024

THIS BOOKLET INCLUDES:

Information concerning the benefit structure and operation of the Southern California Local Union 831 - Employer Health Fund.

Eligibility rules on how you and your Dependents become eligible for benefits and how eligibility may be terminated.

An explanation of how to file claims and appeals.

Phone numbers of those who can answer your questions and help you follow this Plan's rules.

Definitions of capitalized terms in this booklet appear in SECTION 18.

THIS BOOKLET EXPLAINS THE FOLLOWING BENEFITS:

The Indemnity Medical Plan administered by Anthem Blue Cross ("Anthem") for Participants who have not selected the Kaiser Permanente ("Kaiser") plan.

Prescription drug benefits for Participants who have not selected the Kaiser plan.

Dental Benefits.

Vision Benefits.

Death Benefit and Accidental Death and Dismemberment Insurance.

If you have selected the Kaiser plan, your medical and prescription benefits under that plan will be described in a booklet supplied to you by Kaiser.

IMPORTANT TELEPHONE NUMBERS:

The Trust Fund Office .....(877) 572-7005 or
(626) 279-3080
www.localunion831trustfunds.com

Anthem Blue Cross .....(800) 274-7767
www.anthem.com

Optum Rx .....(800) 797-9791
www.optumrx.com

Kaiser Permanente (Multi-Lingual) .....(800) 464-4000
(Spanish) .....(800) 788-0616
www.kp.org

Employee Assistance Program: Claremont EAP…….(800) 834-3773
https://www.claremonteap.com/help-request-form/ and use company name: Local 831

Si usted prefiere información en español acerca de este programa de seguro y sus clausulas, haga favor de comunicarse con la oficina de Fideicomiso, llamando al telefono (626)279-3080.

INTRODUCTION AND PREAMBLE

The Nature of this Plan and the Power of the Trustees to Modify, Reduce and Eliminate Plan Benefits and to Restrict Use of this Plan Without Prior Notice

This booklet has been prepared to provide you with a general description of the structure and operation of, and other information concerning, the Southern California Local Union 831 - Employer Health Fund (the "Plan") and the benefits it provides. The Trustees want you to know the purpose for which this Plan was designed, how and when you become eligible for coverage, and the benefits you can receive from it.

We urge you to read this booklet carefully so that you may become thoroughly familiar with this Plan and that you share it with your covered family members.

The benefits provided under this Plan are made possible by monies received by the Plan primarily as a result of the collective bargaining agreements negotiated between employers and Painters District Council 36 on behalf of the Trade Show & Sign Crafts Local Union 831.

The monies received by this Plan and the benefits provided by this Plan are maintained and administered under the direction of the Board of Trustees of the Plan. Half of the Trustees are representatives appointed by Painters District Council 36 on behalf of the Trade Show & Sign Crafts Local Union 831 and half are appointed by participating employers. The Trustees serve without pay as a service to the industry, the employees, and other individuals participating in this Plan.

The Board of Trustees attempts to develop and maintain an overall program of benefits that can be purchased with the monies being received and that will be of most value to all Plan Participants. The Board generally has no power to require employers to pay more money than what's called for by the participating agreements to this Plan to help this Plan maintain benefits at a particular level. Consequently, in order for the Board of Trustees to maintain responsible control over the financial condition of this Plan, the Board will constantly monitor and control the level of benefits being offered. The Board may, at any time, make changes in the type and amount of benefits provided under this Plan and in the eligibility requirements of this Plan. This may include, for example, increases or decreases in the number of hours which a covered Employee is permitted to accumulate in the Benefit Credit Bank, which is explained more fully in this booklet. It also may include the immediate elimination or addition of a type of benefit, increases or decreases in the amount of the deductible payment or in the percentage of charges covered, and, for Participants enrolled in the Kaiser plan, a change in benefits for that plan or elimination or replacement of the Kaiser plan. The Trustees also have the discretion to terminate this Plan.

In order to ensure that all who benefit from this Plan do so appropriately and only to the extent to which they are entitled, the Board of Trustees reserves the right and authority to impose upon Participants and beneficiaries restrictions with respect to their rights to receive benefits from this Plan. The Trustees also reserve the right to refuse payment for services rendered or facilities or supplies furnished by particular health care providers. These powers may be used as the Trustees

deem necessary as, for example, when the Trustees determine that a Participant or beneficiary or healthcare provider has made any misrepresentation (whether or not intentional) in connection with claims for benefits or has committed any act or omission resulting in abuse or misuse of this Plan. The Trustees further reserve the right to deduct from benefits due on behalf of you or any family member the amount of any benefit incorrectly paid or not reimbursed to this Plan by you, that family member, or any other family member. Finally, the Trustees reserve the right to seek reimbursement and other damages, together with attorney's fees (to the extent provided by law) and other costs incurred in connection with recovering any benefits incorrectly paid or not reimbursed to this Plan when reimbursement is required.

While the Trustees will attempt to give advance notice of changes and of the imposition of restrictions, they reserve full power and authority to make such changes and impose such restrictions without giving advance notice to any Participants and beneficiaries or health care providers, except as may be required by law.

The Trustees have the sole, full and exclusive discretionary authority to determine all questions regarding eligibility for benefits, to determine the nature and scope of benefits to be provided, to make rules and regulations necessary for the administration of this Plan, and to construe the terms and provisions of the trust and this summary plan description. All such decisions, determinations and construction shall be final and binding on all parties.

Board of Trustees, January 1, 2024

Jon Coley
Painters District Council 36

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Nth Degree

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SOUTHERN CALIFORNIA LOCAL UNION 831 – EMPLOYER HEALTH FUND
SUMMARY PLAN DESCRIPTION

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SECTION 1

PREFERRED PROVIDER ORGANIZATION (PPO) NETWORK GUIDELINES

The provider network for the Indemnity/PPO Plan is the Anthem Blue Cross Prudent Buyer Network (the "PPO network"). ***If you have selected the Kaiser HMO plan, your medical and prescription benefits under that plan will be described in a separate booklet supplied to you by Kaiser***.

Protect yourself from unnecessary out-of-pocket expenses by always verifying that your provider is still part of the PPO network.

The PPO network is a voluntary option which will save you money. *If you use a PPO network provider (called a PPO provider in this booklet), your benefit will be a percentage of the more generous contracted rates rather than a percentage of "usual, customary and reasonable" ("UCR") fees for an out-of-network provider (called a non-PPO provider). (See example on the following page.) If you use a non-PPO provider, any amount the provider charges over the allowed amount will also be billed to you, except for No Surprises Services.* For more information on No Surprises Services, see Section 17.

The PPO network gives you access to a complete network of PPO providers of quality health care at reasonable costs. This network includes many of the major hospitals throughout Southern California. It also includes physicians, laboratories, x-ray facilities and other service providers.

For a list of PPO providers go to www.anthem.com or call (800) 274.7767.

Whenever you are scheduled for a procedure that includes more than one provider (i.e., anesthesiologist, specialist, lab work) be sure that each provider is a PPO provider. Just because the referring doctor is in our PPO network does not mean the other providers are also in the PPO network.

The advantages of using a PPO provider:

You will be afforded quality health care.

You will save money through lower rates and a higher percentage paid.

The Plan will save money.

The provider will file health claims for you.

PPO v. Non-PPO Example

Using a PPO provider can save you money. The following example shows how this Plan would process a $1,000 bill for Medically Necessary services under Levels 1, 2 and 3.

The amount you would pay to the PPO provider ($75.00) is dramatically lower than what you would pay to the non-PPO provider ($360.00).

PPO provider		Non-PPO provider
$1,000	Billed charges	$1,000
$250	PPO discount	N/A
$750 (PPO rate)	Allowed amount	$800 (UCR)
90%	Plan Pays (%)	80%
$75	Your co-insurance	$160
$0	Balance billed amount	$200
$75	**YOUR TOTAL COST**	**$360**

ABOUT THE PPO NETWORK

Should I Choose a Primary Care Physician?

The PPO network has both primary care physicians and specialists. The PPO network primary care physicians are family practitioners, internists, obstetricians/gynecologists and pediatricians who have agreed to accept discounted rates and can refer you to other participating providers.

It is to your benefit to establish a close relationship with a primary care physician so that he or she can become familiar with your health care needs and help to advise you on healthcare matters. Whenever you feel it is necessary to change physicians, you may do so. You and your enrolled Dependents may each select a different primary care physician if you so choose.

You may obtain a list of providers in your area by calling the Trust Fund Office at (877) 572-7005 or (626) 279-3080. If you have access to internet service, you may go online at www.anthem.com to obtain a list of providers.

What About Referrals to Specialists?

Your primary care physician will refer you to other providers such as specialists, laboratories, or radiology facilities if necessary. *Be sure to remind your doctor to refer you to a PPO provider.* Coordination of your medical care through one physician avoids duplication and conflicting treatments. You may, however, go directly to a PPO network specialist without a referral and still take advantage of the PPO rates.

What Are My Financial Responsibilities?

One of the advantages of using PPO providers is that they have agreed to charge network patients only for deductibles, coinsurance and non-covered services. Once you authorize assignment of benefits to the provider, you do not have to pay the full provider bill up front. You pay only the amounts you owe under this Plan after you receive an Explanation of Benefits from the Trust Fund Office.

Coordination of Benefits

The PPO network contract rates ("PPO rates") apply if this Plan is either your primary or secondary coverage. This plan would be secondary, for example, for a spouse who has primary coverage under another health plan. If this plan is secondary coverage, be sure to attach the "Explanation of Benefits" from the primary plan to any claim submitted to this Plan.

SECTION 2

PRE-ADMISSION AND UTILIZATION REVIEW

If you are admitted to a hospital or facility for inpatient care, pre-admission and utilization review is required to assure that you receive both the appropriate service and the highest level of benefit available from this Plan. These pre-admission and utilization review requirements apply to all plan levels of the Indemnity/PPO Plan through Anthem.

Pre-admission Review for Scheduled Admissions

It is important to confirm that any planned services are medically necessary and appropriate to your needs. Pre-authorization must be performed before you enter any hospital for any non-emergency admission.

If you are scheduled for a hospital stay, your physician should call Anthem at 1-800-274-7767 for preauthorization before you are admitted. Please remind your physician to do so. You should also show your health plan card to the admissions personnel at the facility when you are admitted to be sure the preauthorization has been completed.

As part of the pre-admission review, Anthem may determine that all or part of the proposed admission or the planned procedures are not medically necessary. Anthem may also determine that the services could be provided on an outpatient basis, rather than inpatient in the hospital or facility.

Emergency Admission Review

If you are admitted to a hospital in an emergency, there is no requirement for preauthorization. However, your physician or the admissions personnel must call Anthem within 24 hours of your admission to initiate an emergency admission review.

Continued Hospital Stay Review

Hospital stays that are not medically necessary are not covered by the Plan. Anthem will conduct periodic reviews during your hospital stay to determine whether continued hospitalization is appropriate and whether coverage will continue.

Reduction in Benefit Payable if You Do Not Obtain Pre-authorization

For PPO Providers and Non-PPO Providers, failure to follow the Pre-authorization procedures may result in denial of benefits or a benefit reduction.

SECTION 3

SCHEDULE OF COVERAGE – LEVEL 1

The following is a description of the benefits available to those covered under Level 1. If you are covered under Level 1 and have chosen the Kaiser plan, most of your benefits are described in the Kaiser Booklet that may be obtained from Kaiser or the Trust Fund Office. The Durable Medical Equipment, Chiropractic, Dental, Orthodontia, Vision, and Death benefits described in this section apply to Kaiser Participants as well as Participants in the Indemnity Plan.

Major Medical Benefits

Deductibles

Individual Deductible

The individual deductible is $300 per calendar year for each covered person. Covered expenses are applied toward the individual deductible in the year in which they are incurred. If the deductible is not met in a particular year, covered expenses incurred in the last 3 months of that year will be applied toward the individual deductible for the next year.

Family Deductible

The family deductible is $600 per calendar year per family. Once the family deductible has been met for a calendar year, no further individual deductible need be met for that family in that calendar year. Covered expenses are applied toward the family deductible in the year in which they are incurred. Covered expenses in the last 3 months of the year are not applied toward the family deductible for the next year.

Individual Out-of-Pocket Maximum

100% of eligible expenses will be paid after you have had eligible PPO out-of-pocket expenses of $4,900 in a calendar year. All remaining eligible expenses for that year will be reimbursed at up to 100% of the PPO rate when you use PPO providers or at 100% of UCR when you use non-PPO providers.

This maximum applies to each family member separately.

Not included in the out-of-pocket maximum are your share of benefits paid at 50%, your share of benefits paid in excess of this Plan's maximums, and your payment of benefits in excess of UCR for non-PPO providers.

Level of Reimbursement:

This Plan will pay at the percentage listed below for covered expenses that:

1. are incurred by you or your Dependents while covered;

2. are due to your or your Dependent's sickness or injury;

3. are ordered by and while you or your Dependents are under the direct care of a Physician;

4. are Medically Necessary, as defined herein;

5. are not excluded from coverage by the "Exclusions" or "Limitations" sections of this Plan; and

6. exceed the deductibles and are within this Plan's limitations as shown in the Schedule of Coverage for your plan level.

This Plan generally pays 90% of the PPO rate when you use PPO providers, and 90% of UCR when you use a non-PPO provider only if you had no choice but to use a non-PPO provider, and in all cases obtain preauthorization when required. This Plan generally pays 80% of UCR when you use a non-PPO provider and obtain preauthorization when required. For PPO providers and non-PPO providers, failure to follow the preauthorization procedures may result in denial of benefits or a benefit reduction.

Immunizations

100% of the PPO rate will be paid when you use a PPO provider.

100% of UCR will be paid when you use a non-PPO provider.

Not subject to the deductible.

COVID-19 Testing

Coronavirus (COVID-19) testing, including over-the-counter tests, and any costs of items or services related to the administration of such testing, when furnished during a health care provider office visit (including a telehealth visit), urgent care center visit, or emergency room visit will be covered at:

90% of the Anthem Blue Cross allowable amount, when you use a PPO provider, subject to the Plan's deductible.

80% of UCR, when you use a non-PPO provider, subject to the Plan's deductible.

Vaccines - Seasonal Influenza and Shingles

This Plan has contracted with the pharmacy networks listed below to provide flu and shingles vaccinations at no charge, to Employees and Dependents. For the flu vaccine, you don't have to see a doctor first to receive vaccinations at no out-of-pocket cost. For the shingles vaccine (Zostavax), you will need a doctor's prescription in order to have the vaccine administered at no cost to you at a participating pharmacy. You are still able to go outside of these pharmacy networks to receive a flu shot or the shingles vaccine, but you may have to pay some or all of the cost. We recommend that you check with the following pharmacies for vaccine availability, then go to your nearest location and show them your Optum Rx Card (and, for the shingles vaccine, a doctor's prescription) to get your vaccinations at no out-of-pocket cost to you:

Vons/Pavilions/Safeway
Ralphs
Raley's
Albertsons
Stater Brothers
CVS
Rite Aid

Kaiser Plan Participants/Dependents: We recommend that you call Kaiser's Customer Service line or your local medical clinic to find out how you can receive your flu shot and the shingle vaccine (Zostavax) without having to pay an office visit or other out-of-pocket charge. Kaiser Participants must receive their flu and shingles vaccinations through a Kaiser facility, per Kaiser guidelines.

Chiropractic Care, Physical Therapy and Acupuncture

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Limited to 18 visits for any combination of these services in a calendar year. Requests for future additional visits (but no more than six for each request) during that calendar year must be accompanied by satisfactory proof of medical necessity.

Kaiser Participants: Physical Therapy is covered at Kaiser, Chiropractic Care is covered through the Indemnity Plan, and Acupuncture is not covered.

Diabetes Instructional Course

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Limited to one diabetes instructional course per year based on medical necessity.

Elective Abortions

This Plan will cover elective abortions for Participants and Dependents.

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Durable Medical Equipment

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Preauthorization is required for purchases in excess of $500 and for all rental equipment.

Ground and Air Ambulance Service

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

NOTE: 100% of UCR will be paid to transfer a patient from a non-PPO Hospital to a PPO Hospital which is within 50 miles of the non-PPO Hospital when the transfer is approved by the attending physician and by Anthem.

Hospital Room & Board Level of Reimbursement

90% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization when required.

80% of UCR will be paid when you use a non-PPO Hospital.

Outpatient Surgical Facility -- Non-PPO Rates by County

If you receive outpatient surgery at a non-PPO facility, this Plan will pay 80% of the facility's rate up to the maximum shown below for each county:

County (where facility located):	**Maximum Rate Per Surgery:**
Los Angeles/Orange/San Diego:	$2,900.00 (Plan pays 80%)
Riverside/San Bernardino:	$2,450.00 (Plan pays 80%)
San Luis Obispo/Santa Barbara/Kern:	$1,910.00 (Plan pays 80%)

Ventura:	$2,340.00 (Plan pays 80%)

Annual Physical Exams

100% of the PPO allowance will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Not subject to the deductible.

Covers routine physical exams, mammograms, pap smears, prostate special antigen (PSA) tests, all routine lab work, bone-density screening, routine colonoscopies, and adult immunizations.

Physician Assistants

This Plan will cover physician assistants who perform Medically Necessary services within the scope of their license.

Second Surgical Opinion

100% of UCR will be paid for a second opinion for surgery but only when the second opinion is arranged by Anthem. Otherwise, 80% of UCR will be paid.

Skilled Nursing Facility/Convalescent Hospital/Home Health Care

90% of the PPO rate will be paid when you use a PPO facility and obtain preauthorization.

When you use a non-PPO facility, this Plan will pay 50% of the contracted daily rate of the nearest PPO facility to the non-PPO facility where the services are rendered.

Maximum of 60 days per admission, even if you transition between a skilled nursing facility, convalescent hospital or home health care during that time frame. Pre-authorization is required.

Hospice Care

90% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization.

80% of UCR will be paid when you use a non-PPO provider.

For PPO Providers and Non-PPO Providers, failure to follow the preauthorization procedures, may result in denial of benefits or a benefit reduction.

Smoking Cessation

The smoking cessation benefit will allow you to receive smoking cessation products.

Covered products will include both prescription and over-the-counter nicotine replacement patches and/or gum. Covered purchases will be subject to the current prescription co-pay for a 30-day supply.

This Plan will reimburse up to $100.00 per lifetime upon your submission of your proof-of-purchase of a smoking cessation course.

Sterilization/Reversal of Sterilization/Infertility

Sterilization is a covered procedure. Charges for reversal of sterilization, infertility procedures, and sex changes are not eligible for reimbursement.

90% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization.

80% of UCR will be paid when you use a non-PPO provider.

Supplemental Accident Benefit

If you are in an accident, the Plan will pay you a lump sum benefit of up to $300.00 per accident for treatment of Accidental Injuries, should you be subject to any out-of-pocket costs after regular benefits under the Plan are applied. You must submit a bill outlining your out-of-pocket expenses within 90 days of the accident or injury. Any out-of-pocket costs covered by this supplemental accident benefit will still apply towards your out-of-pocket maximum.

Transplant

Benefits will be provided to an organ transplant recipient who is covered under this Plan, except where the procedures are experimental, coverage is available through other group coverage or coverage is available through any government-funded program.

In addition, the donor of an organ for transplant to a covered recipient will be provided inpatient benefits for a maximum of 10 days up to a maximum of $10,000 toward all donor medical expenses. Such benefits will not be provided when donor benefits are available through other group coverage or government funding of any kind.

Prescription Drugs

NOTE: You are eligible for prescription drug benefits only if you have Level 1, Level 2 or Level 3 Coverage. If you have Level 1, Level 2 or Level 3 Indemnity Plan Benefits,

you are covered by the Optum Rx program outlined below. If you have Level 1, Level 2 or Level 3 Kaiser coverage, contact Kaiser regarding your prescription drug benefits.

Prescription drug benefits are not subject to a deductible. The Plan will pay for 80% of any retail prescription you fill at a participating pharmacy and 90% of any prescription you obtain by mail order through Optum Rx.

Prescription Drug Card at Walk-In Participating Pharmacies

In order to have your covered prescriptions filled and paid by this Plan, you must present your Optum Rx card at a participating pharmacy.

The participating pharmacy will fill your prescription and provide you with up to a 30-day supply of most medication. You will be charged 20% of the cost of the prescription.

The cost of the prescription will be based on a discount negotiated by Optum Rx and will use generic drugs whenever appropriate.

If you have any questions or need help in locating a participating pharmacy, go to www.optumrx.com or call (800) 797-9791.

After the first fill, a prescription may be refilled twice at a walk-in pharmacy (for a total of 3 fills at retail). Subsequent refills must be done through the mail order program described below.

Mail Order

You will be charged 10% of the cost of the prescription. All maintenance drugs must be purchased through the mail order program after the first three fills at a retail pharmacy. For mail order forms, go to www.optumrx.com or call (800) 797-9791.

Payment as Secondary Insurance

If you or any of your Dependents have primary prescription coverage under another plan and the prescriptions are also eligible for coverage under this Plan, this Plan will pay 80% of the other plan's participant co-pay requirement (limited to covered prescriptions).

Dental Benefits

See SECTION 7 for more detailed information about dental benefits available to you and your Dependents.

Deductible

No deductible for the Employee.

$25.00 per calendar year deductible for each covered Dependent.

Level of Reimbursement

80% of the PPO allowance if you use a PPO provider or 80% of UCR if you use a non-PPO provider.

Calendar Year Maximum

$2,000 per individual over age 19.

Orthodontia Benefits

NOTE: Orthodontia benefits are available to Dependent children only up to age 26.

Lifetime Maximum

$3,500 per Dependent. This maximum does not apply to medically necessary orthodontia.

No benefits are payable for orthodontic banding or appliances attributable to periods prior to the date the covered person became covered under this Plan. All charges for such orthodontic banding or appliances must be billed at the beginning of a course of treatment.

Vision Benefits

You are only eligible for Vision Benefits if you have Level 1 or Level 2 Benefits.

The Plan pays vision care benefits for services and supplies received by you or your covered Dependents as follows:

Plan deductible does not apply to Vision benefits.

1 pair of lenses or contact lenses in each 12 consecutive month period, with complete visual analysis including case history, refraction, etc., by a licensed ophthalmologist or optometrist, based on the following schedule (dollar limits apply only to individuals age 19 or older).

For dependent children under the age of 19, there will be no frequency limitations for the replacement of lenses or frames if more frequent replacement is medically necessary.

As with all PPO providers, Vision PPO providers are subject to the PPO rates.

Examination (Refraction)	$90.00

If you have selected the Kaiser Plan, your vision exam benefit, with the exception of vision exams for contact lens prescriptions, is provided by Kaiser directly and your vision benefit is described in a separate booklet provided by Kaiser. Vision exams for contact lens prescriptions for Kaiser Participants are covered through the Indemnity Plan as described above.

Single Vision Lenses (once every 12 months)	$112.50
Bifocal Lenses	$150.00
Trifocal Lenses	$180.00
Progressive Lenses	$180.00
Lenticular Lenses	$180.00
Contact Lenses/each	$150.00
Polycarbonate Lenses/Pair (Benefit for Employees Only)*	$75.00
Frames (once every 24 months):	$150.00

*Polycarbonate Lenses are covered only if required by an Employer.

No benefits are payable for:

1. Expenses for any services or supplies covered by any other part of this Plan;

2. Special procedures or items such as:

a. orthoptics,

b. vision training,

c. subnormal vision aids,

d. plain sunglasses,

e. anti-reflective or anti-scratch coatings,

f. special vision testing except as provided by an ophthalmologist or optometrist,

g. medical or surgical treatment of the eyes, or

h. services or supplies not listed as covered expenses.

3. Expenses otherwise excluded or limited by this Plan.

Hearing Aid Benefit

This Plan will pay the following amounts in relation to hearing aids, whether prescribed or purchased over-the-counter:

Audiologist visit (hearing test)	up to $75.00 per visit
Ear Molds	up to $50.00 per mold
Hearing Aid	up to $800.00 per ear

Plan deductible does not apply to Hearing Aid benefits.

The audiologist visit (hearing test) is limited to one per year. Ear molds and hearing aids are limited to one every four years for each ear; except that, for an eligible child up to age 19, ear molds are allowed up to twice a year, if needed, for each ear (eligible Dependents age 19 or over are subject to the four-year limit).

If you are a Kaiser Participant, you must have your hearing examination performed at a Kaiser facility. You may then purchase your hearing aids from any vendor and submit your bill to the Trust Fund Office for reimbursement.

Death Benefits — Based on Current Eligibility for Health Coverage

$25,000 is payable to the designated beneficiary in the event of the death of the Employee while covered under the Plan. However, the $25,000 benefit will be reduced depending on the Employee's age at the time of death based on the following:

Your Age	**Your % Reduction**
65 to 69	35%
70 or older	50%

$5,000 in additional accidental death benefits are payable to the designated beneficiary in the event of a death of the Employee due to an Accidental Injury while covered under the Plan.

Up to $5,000 in accidental dismemberment benefits are payable to the Employee in the event of dismemberment of the Employee due to an Accidental Injury while covered under the Plan.

Upon termination of your eligibility for death benefits, you will have 30 days should you wish to convert your coverage under our group policy to an individual policy where you personally pay the premiums. Contact the Trust Fund Office for additional details.

Note: In order to receive maximum benefits and avoid confusion about any of your benefits, please call Anthem at (800) 274-7767 prior to any services being rendered. Hospital services require pre-authorization before a scheduled admission or within 24 hours of an emergency admission.

IMPORTANT TELEPHONE NUMBERS:

The Trust Fund Office .....(877) 572-7005 or (626) 279-3080

Anthem Blue Cross.....(800) 274-7767 or www.anthem.com

Optum Rx.....(800) 797-9791 or www.optumrx.com

Kaiser Permanente (Multi-Lingual).....(800) 464-4000

(Spanish) .....(800) 788-0616
www.kp.org

Employee Assistance Program: Claremont EAP……..(800) 834-3773
https://www.claremonteap.com/help-request-form/ and use company name: Local 831

SECTION 4

SCHEDULE OF COVERAGE – LEVEL 2

The following is a description of the benefits available to those covered under Level 2. If you are covered under Level 2 and have chosen the Kaiser plan, most of your benefits are described in the Kaiser Booklet that can be obtained from the Trust Fund Office. The Durable Medical Equipment, Chiropractic, Dental, Orthodontia, Vision, and Death benefits described in this section apply to Kaiser Participants as well as Participants in the Indemnity Plan.

Major Medical Benefits

Deductibles

Individual Deductible

The individual deductible is $300 per calendar year for each covered person. Covered expenses are applied toward the individual deductible in the year in which they are incurred. If the deductible is not met in a particular year, covered expenses incurred in the last 3 months of that year will be applied toward the individual deductible for the next year.

Family Deductible

The family deductible is $600 per calendar year per family. Once the family deductible has been met for a calendar year, no further individual deductible need be met for that family in that calendar year. Covered expenses are applied toward the family deductible in the year in which they are incurred. Covered expenses in the last 3 months of the year are not applied toward the family deductible for the next year.

Individual Out-of-Pocket Maximum

100% of eligible expenses will be paid after you have had eligible PPO out-of-pocket expenses of $4,900 in a calendar year. All remaining eligible expenses for that year will be reimbursed at up to 100% of the PPO rate when you use PPO providers or at 100% of UCR when you use non-PPO providers.

This maximum applies to each family member separately.

Not included in the out-of-pocket maximum are your share of benefits paid at 50%, your share of benefits paid in excess of this Plan's maximums, and your payment of benefits in excess of UCR for non-PPO providers.

Level of Reimbursement

This Plan will pay at the percentage listed below for covered expenses that:

1. are incurred by you or your Dependents while covered;

2. are due to your or your Dependent's sickness or injury;

3. are ordered by and while you or your Dependents are under the direct care of a Physician;

4. are Medically Necessary, as defined herein;

5. are not excluded from coverage by the "Exclusions" or "Limitations" sections of this Plan; and

6. exceed the deductibles and are within this Plan's limitations as shown in the Schedule of Coverage for your plan level.

This Plan generally pays 90% of the PPO rate when you use PPO providers, and 90% of UCR when you use a non-PPO provider only if you had no choice but to use a non-PPO provider, and in all cases obtain preauthorization when required. This Plan generally pays 80% of UCR when you use a non-PPO provider and obtain preauthorization when required. For PPO providers and non-PPO providers, failure to follow the preauthorization procedures may result in denial of benefits or a benefit reduction.

Immunizations

100% of the PPO rate will be paid when you use a PPO provider.

100% of UCR will be paid when you use a non-PPO provider.

Not subject to the deductible.

COVID-19 Testing

Coronavirus (COVID-19) testing, including over-the-counter tests, and any costs of items or services related to the administration of such testing, when furnished during a health care provider office visit (including a telehealth visit), urgent care center visit, or emergency room visit will be covered at:

90% of the Anthem Blue Cross allowable amount, when you use a PPO provider, subject to the Plan's deductible.

80% of UCR, when you use a non-PPO provider, subject to the Plan's deductible.

Vaccines - Seasonal Influenza and Shingles

This Plan has contracted with the pharmacy networks listed below to provide flu and shingles vaccinations at no charge to Employees and Dependents. For the flu vaccine, you don't have to see a doctor first to receive vaccinations at no out-of-pocket cost. For the shingles vaccine (Zostavax), you will need a doctor's prescription in order to have the vaccine administered at no cost to you at a participating pharmacy. You are still able to go outside of these pharmacy networks to receive a flu shot or the shingles vaccine, but you may have to pay some or all of the cost. We recommend that you check with the following pharmacies for vaccine availability, then go to your nearest location and show them your Optum Rx Card (and, for the shingles vaccine, a doctor's prescription) to get your vaccinations at no out-of-pocket cost to you:

Vons/Pavilions/Safeway	Stater Brothers
Ralphs	CVS
Raley's	Rite Aid
Albertsons	

Kaiser Plan Participants/Dependents: We recommend that you call Kaiser's Customer Service line or your local medical clinic to find out how you can receive your flu shot and the shingle vaccine (Zostavax) without having to pay an office visit or other out-of-pocket charge. Kaiser Participants must receive their flu and shingles vaccinations through a Kaiser facility, per Kaiser guidelines.

Chiropractic Care, Physical Therapy and Acupuncture

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Limited to 18 visits for any combination of these services in a calendar year. Requests for future additional visits (but no more than six for each request) during that calendar year must be accompanied by satisfactory proof of medical necessity.

For Kaiser Participants: Physical Therapy is covered at Kaiser, Chiropractic Care is covered through the Indemnity Plan, and Acupuncture is not covered.

Diabetes Instructional Course

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Limited to one diabetes instructional course per year based on medical necessity.

Elective Abortions

This Plan will cover elective abortions for Participants and Dependents.

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Durable Medical Equipment

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Preauthorization is required for purchases in excess of $500 and for all rental equipment.

Ground and Air Ambulance Service

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

NOTE: 100% of UCR will be paid to transfer a patient from a non-PPO Hospital to a PPO Hospital which is within 50 miles of the non-PPO Hospital when the transfer is approved by the attending physician and by Anthem.

Hospital Room & Board Level of Reimbursement

90% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization when required.

80% of UCR will be paid when you use a non-PPO Hospital.

Outpatient Surgical Facility -- Non-PPO Rates by County

If you receive outpatient surgery at a non-PPO facility, this Plan will pay 80% of the facility's rate up to the maximum shown below for each county:

County (where facility located):	**Maximum Rate Per Surgery:**
Los Angeles/Orange/San Diego:	$2,900.00 (Plan pays 80%)
Riverside/San Bernardino:	$2,450.00 (Plan pays 80%)
San Luis Obispo/Santa Barbara/Kern:	$1,910.00 (Plan pays 80%)

Ventura:	$2,340.00 (Plan pays 80%)

Annual Physical Exams

100% of the PPO allowance will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Not subject to the deductible.

Covers routine physical exams, mammograms, pap smears, prostate special antigen (PSA) tests, all routine lab work, bone-density screening, routine colonoscopies, and adult immunizations.

Physician Assistants

This Plan will cover physician assistants who perform Medically Necessary services within the scope of their license.

Second Surgical Opinion

100% of UCR will be paid for a second opinion for surgery but only when the second opinion is arranged by Anthem. Otherwise, 80% of UCR will be paid.

Skilled Nursing Facility/Convalescent Hospital/Home Health Care

90% of the PPO rate will be paid when you use a PPO facility and obtain preauthorization.

When you use a non-PPO facility, this Plan will pay 50% of the contracted daily rate of the nearest PPO facility to the non-PPO facility where the services are rendered.

Maximum of 60 days per admission, even if you transition between a skilled nursing facility, convalescent hospital or home health care during that time frame. Pre-authorization is required.

Hospice Care

90% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization.

80% of UCR will be paid when you use a non-PPO provider.

For PPO Providers and Non-PPO Providers, failure to follow the preauthorization procedures, may result in denial of benefits or a benefit reduction.

Smoking Cessation

The smoking cessation benefit will allow you to receive smoking cessation products.

Covered products will include both prescription and over-the-counter nicotine replacement patches and/or gum. Covered purchases will be subject to the current prescription co-pay for a 30-day supply.

This Plan will reimburse up to $100.00 per lifetime upon your submission of your proof-of-purchase of a smoking cessation course.

Sterilization/Reversal of Sterilization/Infertility

Sterilization is a covered procedure. Charges for reversal of sterilization, infertility procedures, and sex changes are not eligible for reimbursement.

90% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization.

80% of UCR will be paid when you use a non-PPO provider.

Supplemental Accident Benefit

If you are in an accident, the Plan will pay you a lump sum benefit of up to $300.00 per accident for treatment of Accidental Injuries, should you be subject to any out-of-pocket costs after regular benefits under the Plan are applied. You must submit a bill outlining your out-of-pocket expenses within 90 days of the accident or injury. Any out-of-pocket costs covered by this supplemental accident benefit will still apply towards your out-of-pocket maximum.

Transplant

Benefits will be provided to an organ transplant recipient who is covered under this Plan, except where the procedures are experimental, coverage is available through other group coverage or coverage is available through any government-funded program.

In addition, the donor of an organ for transplant to a covered recipient will be provided inpatient benefits for a maximum of 10 days up to a maximum of $10,000 toward all donor medical expenses. Such benefits will not be provided when donor benefits are available through other group coverage or government funding of any kind.

Prescription Drugs

NOTE: You are eligible for prescription drug benefits only if you have Level 1, Level 2 or Level 3 Coverage. If you have Level 1, Level 2 or Level 3 Indemnity Plan Benefits,

you are covered by the Optum Rx program outlined below. If you have Level 1, Level 2 or Level 3 Kaiser coverage, contact Kaiser regarding your prescription drug benefits.

Prescription drug benefits are not subject to a deductible. The Plan will pay for 80% of any retail prescription you fill at a participating pharmacy and 90% of any prescription you obtain by mail order through Optum Rx.

Prescription Drug Card at Walk-In Participating Pharmacies

In order to have your covered prescriptions filled and paid by this Plan, you must present your Optum Rx card at a participating pharmacy.

The participating pharmacy will fill your prescription and provide you with up to a 30-day supply of most medication. You will be charged 20% of the cost of the prescription.

The cost of the prescription will be based on a discount negotiated by Optum Rx and will use generic drugs whenever appropriate.

If you have any questions or need help in locating a participating pharmacy, go to www.optumrx.com or call (800) 797-9791.

After the first fill, a prescription may be refilled twice at a walk-in pharmacy (for a total of 3 fills at retail). Subsequent refills must be done through the mail order program described below.

Mail Order

You will be charged 10% of the cost of the prescription. All maintenance drugs must be purchased through the mail order program after the first three fills at a retail pharmacy. For mail order forms, go to www.optumrx.com or call (800) 797-9791.

Payment as Secondary Insurance

If you or any of your Dependents have primary prescription coverage under another plan and the prescriptions are also eligible for coverage under this Plan, this Plan will pay 80% of the other plan's participant co-pay requirement (limited to covered prescriptions).

Dental Benefits

See SECTION 7 for more detailed information about dental benefits available to you and your Dependents.

Deductible

$25.00 deductible per calendar year per person.

Level of Reimbursement

70% of the PPO allowance if you use a PPO provider or 70% of UCR if you use a non-PPO provider.

Calendar Year Maximum

$1,500 per individual over age 19.

Orthodontia Benefits

NOTE: Orthodontia benefits are available to Dependent children only up to age 26.

Lifetime Maximum

$3,500 per Dependent. This maximum does not apply to medically necessary orthodontia.

No benefits are payable for orthodontic banding or appliances attributable to periods prior to the date the covered person became covered under this Plan. All charges for such orthodontic banding or appliances must be billed at the beginning of a course of treatment.

Vision Benefits

You are only eligible for Vision Benefits if you have Level 1 or Level 2 Benefits.

The Plan pays vision care benefits for services and supplies received by you or your covered Dependents as follows:

Plan deductible does not apply to Vision benefits

1 pair of lenses or contact lenses in each 12 consecutive month period, with complete visual analysis including case history, refraction, etc., by a licensed ophthalmologist or optometrist, based on the following schedule (dollar limits apply only to individuals age 19 or older).

For dependent children under the age of 19, there will be no frequency limitations for the replacement of lenses or frames if more frequent replacement is medically necessary.

As with all PPO providers, Vision PPO providers are subject to the PPO rates.

Examination (Refraction)	$90.00

If you have selected the Kaiser Plan, your vision exam benefit, with the exception of vision exams for contact lens prescriptions, is provided by Kaiser directly and your vision benefit is described in a separate booklet provided by Kaiser. Vision exams for contact lens prescriptions for Kaiser Participants are covered through the Indemnity Plan as described above.

Single Vision Lenses (once every 12 months)	$112.50
Bifocal Lenses	$150.00
Trifocal Lenses	$180.00
Progressive Lenses	$180.00
Lenticular Lenses	$180.00
Contact Lenses/each	$150.00
Polycarbonate Lenses/Pair (Benefit for Employees Only)*	$75.00
Frames (once every 24 months):	$150.00

*Polycarbonate Lenses are covered only if required by an Employer.

No benefits are payable for:

1. Expenses for any services or supplies covered by any other part of this Plan;

2. Special procedures or items such as

a. orthoptics,

b. vision training,

c. subnormal vision aids,

d. plain sunglasses,

e. anti-reflective or anti-scratch coatings,

f. special vision testing except as provided by an ophthalmologist or optometrist,

g. medical or surgical treatment of the eyes, or

h. services or supplies not listed as covered expenses.

3. Expenses otherwise excluded or limited by this Plan.

Hearing Aid Benefit

This Plan will pay the following amounts in relation to hearing aids, whether prescribed or purchased over-the-counter:

Audiologist visit (hearing test)	up to $75.00 per visit
Ear Molds	up to $50.00 per mold
Hearing Aid	up to $800.00 per ear

Plan deductible does not apply to Hearing Aid benefits.

The audiologist visit (hearing test) is limited to one per year. Ear molds and hearing aids are limited to one every four years for each ear; except that, for an eligible child up to age

19, ear molds are allowed up to twice a year, if needed, for each ear (eligible Dependents age 19 or over are subject to the four-year limit).

If you are a Kaiser Participant, you must have your hearing examination performed at a Kaiser facility. You may then purchase your hearing aids from any vendor and submit your bill to the Trust Fund Office for reimbursement.

Death Benefits — Based on Current Eligibility for Health Coverage

$25,000 is payable to the designated beneficiary in the event of the death of the Employee while covered under the Plan. However, the $25,000 benefit will be reduced depending on the Employee's age at the time of death based on the following:

Your Age	**Your % Reduction**
65 to 69	35%
70 or older	50%

$5,000 in additional accidental death benefits are payable to the designated beneficiary in the event of a death of the Employee due to an Accidental Injury while covered under the Plan.

Up to $5,000 in accidental dismemberment benefits are payable to the employee in the event of dismemberment of the Employee due to an Accidental Injury while covered under the Plan.

Upon termination of your eligibility for death benefits, you will have 30 days should you wish to convert your coverage under our group policy to an individual policy where you personally pay the premiums. Contact the Trust Fund Office for additional details.

Note: In order to receive maximum benefits and avoid confusion about any of your benefits, please call Anthem at (800) 274-7767 prior to any services being rendered. Hospital services require pre-authorization before a scheduled admission or within 24 hours of an emergency admission.

IMPORTANT TELEPHONE NUMBERS:

The Trust Fund Office .....(877) 572-7005 or
(626) 279-3080

Anthem Blue Cross.....(800) 274-7767 or
www.anthem.com

Optum Rx.....(800) 797-9791 or
www.optumrx.com

Kaiser Permanente (Multi-Lingual).....(800) 464-4000
(Spanish) .....(800) 788-0616
www.kp.org

Employee Assistance Program: Claremont EAP……..(800) 834-3773
https://www.claremonteap.com/help-request-form/ and use company name: Local 831

SECTION 5

SCHEDULE OF COVERAGE – LEVEL 3

The following is a description of the benefits available to those covered under Level 3. If you are covered under Level 3 and have chosen the Kaiser plan, most of your benefits are described in the Kaiser Booklet that can be obtained from the Trust Fund Office. The Durable Medical Equipment, Chiropractic, Dental, Orthodontia, and Death benefits described in this section apply to Kaiser Participants as well as Participants in the Indemnity Plan.

Major Medical Benefits

Deductibles

Individual Deductible

The individual deductible is $300 per calendar year for each covered person. Covered expenses are applied toward the individual deductible in the year in which they are incurred. If the deductible is not met in a particular year, covered expenses incurred in the last 3 months of that year will be applied toward the individual deductible for the next year.

Family Deductible

The family deductible is $600 per calendar year per family. Once the family deductible has been met for a calendar year, no further individual deductible need be met for that family in that calendar year. Covered expenses are applied toward the family deductible in the year in which they are incurred. Covered expenses in the last 3 months of the year are not applied toward the family deductible for the next year.

Individual Out-of-Pocket Maximum

100% of eligible expenses will be paid after you have had eligible PPO out-of-pocket expenses of $4,900 in a calendar year. All remaining eligible expenses for that year will be reimbursed at up to 100% of the PPO rate when you use PPO providers or at 100% of UCR when you use non-PPO providers.

This maximum applies to each family member separately.

Not included in the out-of-pocket maximum are your share of benefits paid at 50%, your share of benefits paid in excess of this Plan's maximums, and your payment of benefits in excess of UCR for non-PPO providers.

Level of Reimbursement

This Plan will pay at the percentage listed below for covered expenses that:

1. are incurred by you or your Dependents while covered;

2. are due to your or your Dependent's sickness or injury;

3. are ordered by and while you or your Dependents are under the direct care of a Physician;

4. are Medically Necessary, as defined herein;

5. are not excluded from coverage by the "Exclusions" or "Limitations" sections of this Plan; and

6. exceed the deductibles and are within this Plan's limitations as shown in the Schedule of Coverage for your plan level.

This Plan generally pays 90% of the PPO rate when you use PPO providers, and 90% of UCR when you use a non-PPO provider only if you had no choice but to use a non-PPO provider, and in all cases obtain preauthorization when required. This Plan generally pays 80% of UCR when you use a non-PPO provider and obtain preauthorization when required. For PPO providers and non-PPO providers, failure to follow the preauthorization procedures may result in denial of benefits or a benefit reduction.

Immunizations

100% of the PPO rate will be paid when you use a PPO provider.

100% of UCR will be paid when you use a non-PPO provider.

Not subject to the deductible.

COVID-19 Testing

Coronavirus (COVID-19) testing, including over-the-counter tests, and any costs of items or services related to the administration of such testing, when furnished during a health care provider office visit (including a telehealth visit), urgent care center visit, or emergency room visit will be covered at:

90% of the Anthem Blue Cross allowable amount, when you use a PPO provider, subject to the Plan's deductible.

80% of UCR, when you use a non-PPO provider, subject to the Plan's deductible.

Vaccines - Seasonal Influenza and Shingles

This Plan has contracted with the pharmacy networks listed below to provide flu and shingles vaccinations at no charge to Employees and Dependents. For the flu vaccine, you don't have to see a doctor first to receive vaccinations at no out-of-

pocket cost. For the shingles vaccine (Zostavax), you will need a doctor's prescription in order to have the vaccine administered at no cost to you at a participating pharmacy. You are still able to go outside of these pharmacy networks to receive a flu shot or the shingles vaccine, but you may have to pay some or all of the cost. We recommend that you check with the following pharmacies for vaccine availability, then go to your nearest location and show them your Optum Rx Card (and, for the shingles vaccine, a doctor's prescription) to get your vaccinations at no out-of-pocket cost to you:

Vons/Pavilions/Safeway	Stater Brothers
Ralphs	CVS
Raley's	Rite Aid
Albertsons	

Kaiser Plan Participants/Dependents: We recommend that you call Kaiser's Customer Service line or your local medical clinic to find out how you can receive your flu shot and the shingle vaccine (Zostavax) without having to pay an office visit or other out-of-pocket charge. Kaiser Participants must receive their flu and shingles vaccinations through a Kaiser facility, per Kaiser guidelines.

Chiropractic Care, Physical Therapy and Acupuncture

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Limited to 18 visits for any combination of these services in a calendar year. Requests for future additional visits (but no more than six for each request) during that calendar year must be accompanied by satisfactory proof of medical necessity.

For Kaiser Participants: Physical Therapy is covered at Kaiser, Chiropractic Care is covered through the Indemnity Plan, and Acupuncture is not covered.

Diabetes Instructional Course

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Limited to one diabetes instructional course per year based on medical necessity.

Elective Abortions

This Plan will cover elective abortions for Participants and Dependents.

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Durable Medical Equipment

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Preauthorization is required for purchases in excess of $500 and for all rental equipment.

Ground and Air Ambulance Service

90% of the PPO rate will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

NOTE: 100% of UCR will be paid to transfer a patient from a non-PPO Hospital to a PPO Hospital which is within 50 miles of the non-PPO Hospital when the transfer is approved by the attending physician and by Anthem.

Hospital Room & Board Level of Reimbursement

90% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization when required.

80% of UCR will be paid when you use a non-PPO Hospital.

Outpatient Surgical Facility -- Non-PPO Rates by County

If you receive outpatient surgery at a non-PPO facility, this Plan will pay 80% of the facility's rate up to the maximum shown below for each county:

County (where facility located):	**Maximum Rate Per Surgery:**
Los Angeles/Orange/San Diego:	$2,900.00 (Plan pays 80%)
Riverside/San Bernardino:	$2,450.00 (Plan pays 80%)
San Luis Obispo/Santa Barbara/Kern:	$1,910.00 (Plan pays 80%)
Ventura:	$2,340.00 (Plan pays 80 %)

Annual Physical Exams

100% of the PPO allowance will be paid when you use a PPO provider.

80% of UCR will be paid when you use a non-PPO provider.

Not subject to the deductible.

Covers routine physical exams, mammograms, pap smears, prostate special antigen (PSA) tests, all routine lab work, bone-density screening, routine colonoscopies, and adult immunizations.

Physician Assistants

This Plan will cover physician assistants who perform Medically Necessary services within the scope of their license.

Second Surgical Opinion

100% of UCR will be paid for a second opinion for surgery but only when the second opinion is arranged by Anthem. Otherwise, 80% of UCR will be paid.

Skilled Nursing Facility/Convalescent Hospital/Home Health Care

90% of the PPO rate will be paid when you use a PPO facility and obtain preauthorization.

When you use a non-PPO facility, this Plan will pay 50% of the contracted daily rate of the nearest PPO facility to the non-PPO facility where the services are rendered.

Maximum of 60 days per admission, even if you transition between a skilled nursing facility, convalescent hospital or home health care during that time frame. Pre-authorization is required.

Hospice Care

90% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization.

80% of UCR will be paid when you use a non-PPO provider.

For PPO Providers and Non-PPO Providers, failure to follow the preauthorization procedures, may result in denial of benefits or a benefit reduction.

Smoking Cessation

The smoking cessation benefit will allow you to receive smoking cessation products.

Covered products will include both prescription and over-the-counter nicotine replacement patches and/or gum. Covered purchases will be subject to the current prescription co-pay for a 30-day supply.

This Plan will reimburse up to $100.00 per lifetime upon your submission of your proof-of-purchase of a smoking cessation course.

Sterilization/Reversal of Sterilization/Infertility

Sterilization is a covered procedure. Charges for reversal of sterilization, infertility procedures, and sex changes are not eligible for reimbursement.

90% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization.

80% of UCR will be paid when you use a non-PPO provider.

Supplemental Accident Benefit

If you are in an accident, the Plan will pay you a lump sum benefit of up to $300.00 per accident for treatment of Accidental Injuries, should you be subject to any out-of-pocket costs after regular benefits under the Plan are applied. You must submit a bill outlining your out-of-pocket expenses within 90 days of the accident or injury. Any out-of-pocket costs covered by this supplemental accident benefit will still apply towards your out-of-pocket maximum.

Transplant

Benefits will be provided to an organ transplant recipient who is covered under this Plan, except where the procedures are experimental, coverage is available through other group coverage or coverage is available through any government-funded program.

In addition, the donor of an organ for transplant to a covered recipient will be provided inpatient benefits for a maximum of 10 days up to a maximum of $10,000 toward all donor medical expenses. Such benefits will not be provided when donor benefits are available through other group coverage or government funding of any kind.

Prescription Drugs

NOTE: You are eligible for prescription drug benefits only if you have Level 1, Level 2 or Level 3 Coverage. If you have Level 1, Level 2 or Level 3 Indemnity Plan Benefits, you are covered by the Optum Rx program outlined below. If you have Level 1, Level 2 or Level 3 Kaiser coverage, contact Kaiser regarding your prescription drug benefits.

Prescription drug benefits are not subject to a deductible. The plan will pay for 80% of any retail prescription you fill at a participating pharmacy and 90% of any prescription you obtain by mail order through Optum Rx.

Prescription Drug Card at Walk-In Participating Pharmacies

In order to have your covered prescriptions filled and paid by this Plan, you must present your Optum Rx card at a participating pharmacy.

The participating pharmacy will fill your prescription and provide you with up to a 30-day supply of most medication. You will be charged 20% of the cost of the prescription.

The cost of the prescription will be based on a discount negotiated by Optum Rx and will use generic drugs whenever appropriate.

If you have any questions or need help in locating a participating pharmacy, go to www.optumrx.com or call (800) 797-9791.

After the first fill, a prescription may be refilled twice at a walk-in pharmacy (for a total of 3 fills at retail). Subsequent refills must be done through the mail order program described below.

Mail Order

You will be charged 10% of the cost of the prescription. All maintenance drugs must be purchased through the mail order program after the first three fills at a retail pharmacy. For mail order forms, go to www.optumrx.com or call (800) 797-9791.

Payment as Secondary Insurance

If you or any of your Dependents have primary prescription coverage under another plan and the prescriptions are also eligible for coverage under this Plan, this Plan will pay 80% of the other plan's participant co-pay requirement (limited to covered prescriptions).

Dental Benefits

See SECTION 7 for more detailed information about dental benefits available to you and your Dependents.

Deductible

$25.00 deductible per calendar year per person.

Level of Reimbursement

60% of the PPO allowance if you use a PPO provider or 60% of UCR if you use a non-PPO provider.

Calendar Year Maximum

$1,200 per individual over age 19.

Orthodontia Benefits

NOTE: Orthodontia benefits are available to Dependent children only up to age 26.

Lifetime Maximum

$3,500 per Dependent. This maximum does not apply to medically necessary orthodontia.

No benefits are payable for orthodontic banding or appliances attributable to periods prior to the date the covered person became covered under this Plan. All charges for such orthodontic banding or appliances must be billed at the beginning of a course of treatment.

Hearing Aid Benefit

This Plan will pay the following amounts in relation to hearing aids, whether prescribed or purchased over-the-counter:

Audiologist visit (hearing test)	up to $75.00 per visit
Ear Molds	up to $50.00 per mold
Hearing Aid	up to $800.00 per ear

Plan deductible does not apply to Hearing Aid benefits.

The audiologist visit (hearing test) is limited to one per year. Ear molds and hearing aids are limited to one every four years for each ear; except that, for an eligible child up to age 19, ear molds are allowed up to twice a year, if needed, for each ear (eligible Dependents age 19 or over are subject to the four-year limit).

If you are a Kaiser Participant, you must have your hearing examination performed at a Kaiser facility. You may then purchase your hearing aids from any vendor and submit your bill to the Trust Fund Office for reimbursement.

Death Benefits — Based on Current Eligibility for Health Coverage

$25,000 is payable to the designated beneficiary in the event of the death of the Employee while covered under the Plan. However, the $25,000 benefit will be reduced depending on the Employee's age at the time of death based on the following:

Your Age	**Your % Reduction**
65 to 69	35%
70 or older	50%

$5,000 in additional accidental death benefits are payable to the designated beneficiary in the event of a death of the Employee due to an Accidental Injury while covered under the Plan.

Up to $5,000 in accidental dismemberment benefits are payable to the employee in the event of dismemberment of the Employee due to an Accidental Injury while covered under the Plan.

Upon termination of your eligibility for death benefits, you will have 30 days should you wish to convert your coverage under our group policy to an individual policy where you personally pay the premiums. Contact the Trust Fund Office for additional details.

Note: In order to receive maximum benefits and avoid confusion about any of your benefits, please call Anthem at (800) 274-7767 prior to any services being rendered. Hospital services require pre-authorization before a scheduled admission or within 24 hours of an emergency admission.

IMPORTANT TELEPHONE NUMBERS:

The Trust Fund Office .....(877) 572-7005 or
(626) 279-3080

Anthem Blue Cross.....(800) 274-7767 or
www.anthem.com

Optum Rx.....(800) 797-9791 or
www.optumrx.com

Kaiser Permanente (Multi-Lingual).....(800) 464-4000
(Spanish) .....(800) 788-0616
www.kp.org

Employee Assistance Program: Claremont EAP……..(800) 834-3773
https://www.claremonteap.com/help-request-form/ and use company name: Local 831

SECTION 6

SCHEDULE OF COVERAGE – LEVEL 4

The following is a description of the benefits available to those covered under Level 4. If you are covered under Level 4 and have chosen the Kaiser plan, most of your benefits are described in the Kaiser Booklet that can be obtained from the Trust Fund Office. The Durable Medical Equipment, Chiropractic, and Death benefits described in this section apply to Kaiser Participants as well as Participants in the Indemnity Plan.

Major Medical Benefits

Deductibles

Individual Deductible

The individual deductible is $300 per calendar year for each covered person. Covered expenses are applied toward the individual deductible in the year in which they are incurred. If the deductible is not met in a particular year, covered expenses incurred in the last 3 months of that year will be applied toward the individual deductible for the next year.

Family Deductible

The family deductible is $600 per calendar year per family. Once the family deductible has been met for a calendar year, no further individual deductible need be met for that family in that calendar year. Covered expenses are applied toward the family deductible in the year in which they are incurred. Covered expenses in the last 3 months of the year are not applied toward the family deductible for the next year.

Individual Out-of-Pocket Maximum

100% of eligible expenses will be paid after you have had eligible PPO out-of-pocket expenses of $4,900 in a calendar year. All remaining eligible expenses for that year will be reimbursed at up to 100% of the PPO rate when you use PPO providers.

This maximum applies to each family member separately.

Not included in the out-of-pocket maximum are your share of benefits paid at 50%, your share of benefits paid in excess of this Plan's maximums, and your payment of any amounts to non-PPO providers.

If non-PPO providers are used, no individual out-of-pocket maximum will apply at this Level. Benefits will continue to be paid at the levels described under Level of Reimbursement below.

Level of Reimbursement

This Plan will pay at the percentage listed below for covered expenses that:

1. are incurred by you or your Dependents while covered;

2. are due to your or your Dependent's sickness or injury;

3. are ordered by and while you or your Dependents are under the direct care of a Physician;

4. are Medically Necessary, as defined herein;

5. are not excluded from coverage by the "Exclusions" or "Limitations" sections of this Plan; and

6. exceed the deductibles and are within this Plan's limitations as shown in the Schedule of Coverage for your plan level.

This Plan generally pays 80% of the PPO rate when you use PPO providers, and 80% of UCR when you use a non-PPO provider only if you had no choice but to use a non-PPO provider, and in all cases obtain preauthorization when required. This Plan generally pays 60% of UCR when you use a non-PPO provider and obtain preauthorization when required. For PPO providers and non-PPO providers, failure to follow the preauthorization procedures may result in denial of benefits or a benefit reduction.

COVID-19 Testing

Coronavirus (COVID-19) testing, including over-the-counter tests, and any costs of items or services related to the administration of such testing, when furnished during a health care provider office visit (including a telehealth visit), urgent care center visit, or emergency room visit will be covered at:

80% of the Anthem Blue Cross allowable amount, when you use a PPO provider, subject to the Plan's deductible.

60% of UCR, when you use a non-PPO provider, subject to the Plan's deductible.

Chiropractic Care, Physical Therapy and Acupuncture

80% of the PPO rate will be paid when you use a PPO provider.

60% of UCR will be paid when you use a non-PPO provider.

Limited to 18 visits for any combination of these services in a calendar year. Requests for future additional visits (but no more than six for each request) during that calendar year must be accompanied by satisfactory proof of medical necessity.

For Kaiser Participants: Physical Therapy is covered at Kaiser, Chiropractic Care is covered through the Indemnity Plan, and Acupuncture is not covered.

Diabetes Instructional Course

80% of the PPO rate will be paid when you use a PPO provider.

60% of UCR will be paid when you use a non-PPO provider.

Limited to one diabetes instructional course per year based on medical necessity.

Elective Abortions

This Plan will cover elective abortions for Participants and Dependents.

80% of the PPO rate will be paid when you use a PPO provider.

60% of UCR will be paid when you use a non-PPO provider.

Durable Medical Equipment

80% of the PPO rate will be paid when you use a PPO provider.

60% of UCR will be paid when you use a non-PPO provider.

Preauthorization is required for purchases in excess of $500 and for all rental equipment.

Ground and Air Ambulance Service

80% of the PPO rate will be paid when you use a PPO provider.

60% of UCR will be paid when you use a non-PPO provider.

NOTE: 100% of UCR will be paid to transfer a patient from a non-PPO Hospital to a PPO Hospital which is within 50 miles of the non-PPO Hospital when the transfer is approved by the attending physician and by Anthem.

Hospital Room & Board Level of Reimbursement

80% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization when required.

60% of UCR will be paid when you use a non-PPO Hospital.

Outpatient Surgical Facility -- Non-PPO Rates by County

If you receive outpatient surgery at a non-PPO facility, this Plan will pay 60% of the facility's rate up to the maximum shown below for each county:

County (where facility located):	**Maximum Rate Per Surgery:**
Los Angeles/Orange/San Diego:	$2,900.00 (Plan pays 60%)
Riverside/San Bernardino:	$2,450.00 (Plan pays 60%)
San Luis Obispo/Santa Barbara/Kern:	$1,910.00 (Plan pays 60%)
Ventura:	$2,340.00 (Plan pays 60 %)

Physician Assistants

This Plan will cover physician assistants who perform Medically Necessary services within the scope of their license.

Second Surgical Opinion

100% of UCR will be paid for a second opinion for surgery but only when the second opinion is arranged by Anthem. Otherwise, 80% of UCR will be paid.

Skilled Nursing Facility/Convalescent Hospital/Home Health Care

80% of the PPO rate will be paid when you use a PPO facility and obtain preauthorization.

When you use a non-PPO facility, this Plan will pay 50% of the contracted daily rate of the nearest PPO facility to the non-PPO facility where the services are rendered.

Maximum of 60 days per admission, even if you transition between a skilled nursing facility, convalescent hospital or home health care during that time frame. Pre-authorization is required.

Hospice Care

80% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization.

60% of UCR will be paid when you use a non-PPO provider.

For PPO Providers and Non-PPO Providers, failure to follow the preauthorization procedures, may result in denial of benefits or a benefit reduction.

Smoking Cessation

The smoking cessation benefit will allow you to receive smoking cessation products.

Covered products will include both prescription and over-the-counter nicotine replacement patches and/or gum. Covered purchases will be subject to the current prescription co-pay for a 30-day supply.

This Plan will reimburse up to $100.00 per lifetime upon your submission of your proof-of-purchase of a smoking cessation course.

Sterilization/Reversal of Sterilization/Infertility

Sterilization is a covered procedure. Charges for reversal of sterilization, infertility procedures, and sex changes are not eligible for reimbursement.

80% of the PPO rate will be paid when you use a PPO Hospital and obtain preauthorization.

60% of UCR will be paid when you use a non-PPO provider.

Transplant

Benefits will be provided to an organ transplant recipient who is covered under this Plan, except where the procedures are experimental, coverage is available through other group coverage or coverage is available through any government-funded program.

In addition, the donor of an organ for transplant to a covered recipient will be provided inpatient benefits for a maximum of 10 days up to a maximum of $10,000 toward all donor medical expenses. Such benefits will not be provided when donor benefits are available through other group coverage or government funding of any kind.

Hearing Aid Benefit

This Plan will pay the following amounts in relation to hearing aids, whether prescribed or purchased over-the-counter:

Audiologist visit (hearing test)	up to $75.00 per visit
Ear Molds	up to $50.00 per mold
Hearing Aid	up to $800.00 per ear

Plan deductible does not apply to Hearing Aid benefits.

The audiologist visit (hearing test) is limited to one per year. Ear molds and hearing aids are limited to one every four years for each ear; except that, for an eligible child up to age 19, ear molds are allowed up to twice a year, if needed, for each ear (eligible Dependents age 19 or over are subject to the four-year limit).

If you are a Kaiser Participant, you must have your hearing examination performed at a Kaiser facility. You may then purchase your hearing aids from any vendor and submit your bill to the Trust Fund Office for reimbursement.

Death Benefits — Based on Current Eligibility for Health Coverage

$25,000 is payable to the designated beneficiary in the event of the death of the Employee while covered under the Plan. However, the $25,000 benefit will be reduced depending on the Employee's age at the time of death based on the following:

Your Age	Your % Reduction
65 to 69	35%
70 or older	50%

$5,000 in additional accidental death benefits are payable to the designated beneficiary in the event of a death of the Employee due to an Accidental Injury while covered under the Plan.

Up to $5,000 in accidental dismemberment benefits are payable to the employee in the event of dismemberment of the Employee due to an Accidental Injury while covered under the Plan.

Upon termination of your eligibility for death benefits, you will have 30 days should you wish to convert your coverage under our group policy to an individual policy where you personally pay the premiums. Contact the Trust Fund Office for additional details.

Note: In order to receive maximum benefits and avoid confusion about any of your benefits, please call Anthem at (800) 274-7767 prior to any services being rendered. Hospital services require pre-authorization before a scheduled admission or within 24 hours of an emergency admission.

IMPORTANT TELEPHONE NUMBERS:

The Trust Fund Office .....(877) 572-7005 or
(626) 279-3080

Anthem Blue Cross.....(800) 274-7767 or
www.anthem.com

Kaiser Permanente (Multi-Lingual).....(800) 464-4000
(Spanish) .....(800) 788-0616
www.kp.org

Employee Assistance Program: Claremont EAP……..(800) 834-3773
https://www.claremonteap.com/help-request-form/ and use company name: Local 831

SECTION 7

DENTAL BENEFITS

NOTE: You are eligible for dental benefits only if you have Level 1, Level 2, or Level 3 benefits under either the Indemnity Plan or Kaiser.

See the "Schedule of Coverage" above for your Level of benefits for information on the costs of dental benefits described below.

PRE-TREATMENT REVIEW

If the expenses for a course of treatment will be more than $500, you should submit a statement from the dentist describing the planned course of treatment. This will help you to understand in advance what dental benefits will be covered and the amount that will be paid by the Plan.

If no "pre-treatment review" statement is submitted, benefits will be reviewed for dental necessity and may result in a denial or in your being responsible for a more significant share of the charges incurred.

The statement should:

1. be on a form approved by this Plan,
2. itemize the dental procedures recommended,
3. show the charge for each dental procedure, and
4. be accompanied by supporting X-rays, if requested by the Trust Fund Office.

COVERED DENTAL SERVICES

The following items will be considered Covered Dental Services under this Plan if they:

1. are prescribed, ordered, or performed by a dentist,
2. are not excluded by any provisions of any section of this Plan,
3. are not covered under any other section of this Plan, and
4. are rendered while the patient is covered by this Plan.

Dental PPO providers are subject to the PPO network rates and non-PPO providers are subject to usual, customary and reasonable allowances as defined by this Plan.

A. Preventive/Diagnostic Dental Procedures

1. Oral exams, including prophylaxis (the cleaning and scaling of teeth). Only two exams per calendar year will be covered;

2. Topical application of sodium fluoride or stannous fluoride for your covered children up to age 19;

3. Sealants are covered for dependent children up to age 15 on permanent teeth only with no restorations for molars; limited to once every 3 years.

4. X-rays. Only one set of full mouth x-rays per calendar year will be covered; one set of bitewings per calendar year or as necessary; and

5. Tests and laboratory exams related to dental procedures.

B. Restorative Dental Procedures

1. Fillings;

2. Extractions;

3. Oral surgery;

4. Space maintainers for your covered Dependents up to age 19;

5. Anesthesia given in connection with covered dental services;

6. Injection of antibiotic drugs by the dentist;

7. Periodontal treatment and treatment of other diseases of the gums and tissues of the mouth;

8. Endodontic treatment and related endodontic surgery, including root canal therapy.

C. Replacement Dental Procedures

1. Repair or re-cementing of crowns, inlays, or bridges;

2. Repair or relining of dentures. Not more than one relining every 12 months.

3. Installing partial or full dentures for the first time due to the extraction of one or more natural teeth. This includes adjustments made within 6 months following the installation;

4. Replacement of an existing partial or full denture, crown, veneers, or fixed bridge by a new denture, crown, veneers, or fixed bridge, or the addition of

teeth to an existing denture or bridge to replace extracted natural teeth. These are covered only if:

a. the existing denture or bridge cannot be made serviceable and was installed at least 5 years before it is replaced; or

b. the existing denture is an intermediate denture and must be replaced by a permanent denture, and the replacement is made within 12 months from the date the intermediate denture was installed; or

c. the replacement or addition of teeth is required to replace one or more natural teeth and after the existing denture or bridge was installed.

Benefits for replacement will not be more than the amount that would be payable for the same type of denture, crown, or fixed bridge that is being replaced.

5. Inlays, onlays, gold fillings, crowns, veneers, and installation of fixed bridges for the first time. Bridges are covered only if they are for replacement of one or more natural teeth.

6. Implants to replace teeth extracted while covered; replacement every 5 years.

D. Incurred Date

The Incurred date for Covered Dental Services is as follows:

Type of Treatment	Incurred Date
Dentures	On the date the impression is taken.
Fixed bridges & crowns	On the date the tooth is first prepared.
Root canal therapy	On the date the tooth is opened by the dentist.
All other treatments	On the date the work is done.

Benefits will be payable only upon completion of the treatment.

E. Least Expensive Course of Treatment

When there is more than one way to properly treat a particular dental problem, benefits will be payable only for the least expensive course of treatment.

EXCLUSIONS

NOTE: These exclusions apply specifically to dental benefits. Please see Section 10, for other applicable exclusions. No benefits will be paid for charges in connection with:

1. Services and supplies for which a Covered Person is not required to pay (subject to the right, if any, of the United States government to recover usual, customary, and reasonable charges for care provided in a military or veterans' hospital);

2. a sickness, injury, or condition

    a. for which benefits are paid or payable under Workers' Compensation or any Occupational Disease or similar law whether such benefits are insured or self-insured; or

    b. that is caused by or connected in any way to employment of the Covered Person. This includes self-employment or employment by others. It applies whether or not Workers' Compensation or any Occupational Disease or similar law covers the charges incurred. It applies whether the charges are covered on an insured or uninsured basis;

3. the replacement of a lost or stolen or the accidental destruction of prosthetic device;

4. charges that are made by someone who is not a dentist or for treatment not performed by a dentist except that the cleaning and scaling of teeth may be performed by a licensed dental hygienist who works under the supervision of a dentist; or

5. prosthetic devices and their fitting, for which treatment began prior to the date the Covered Person became covered under this Plan (This includes bridges and crowns);

6. any act due to war, if declared or not;

7. extra sets of dentures or other appliances;

8. oral cancer screening;

9. sealants (except as described on page 25);

10. education or training programs (this includes oral hygiene or plaque control programs);

11. counseling on diet or nutrition;

12. experimental procedures;

13. failure to keep an appointment;

14. completion of any forms;

15. appliances, restoration, and procedures to straighten or realign teeth or alter vertical dimension or restore occlusion; occlusal guard (night guard);

16. veneers or similar properties of crowns and pontics placed on or replacing teeth, except the anterior teeth;

17. replacement of an implant within 5 years of the initial implant;

18. replacement of dentures made less than 5 years after a preceding placement, except a replacement made necessary by the initial placement of an opposing full denture which necessitates the replacement of an existing denture; or

19. any crown replacement made less than 5 years after preceding placement; or

20. replacement of a removable partial bridge by a fixed bridge made less than 5 years after the initial placement of the partial bridge;

21. replacement of a fixed bridge by a removable partial bridge made less than 5 years after the initial placement of the bridge; or

22. replacement of a veneer within 5 years of the initial veneer;

23. care, treatment, services and supplies:

    a. furnished mainly for cosmetic purposes;

    b. received in a hospital or institution owned or operated by the United States government or any of its agencies (subject to the right, if any, of the United States government to recover usual, customary and reasonable charges for care provided in a military or veterans' hospital);

    c. provided or paid for by any governmental plan or law not restricted to its own civilian employees and their dependents; or

    d. for which benefits are payable under other provisions of this Plan; or

    e. for charges that are more than usual, reasonable and customary for the services and supplies furnished;

24. for Treatment of Temporomandibular Joint (T. M. J.) Dysfunction or Myofascial Pain Dysfunction (M. P. D.).

SPECIFIC DEFINITIONS

As used in this provision:

1. Course of Treatment means all dental services or series of dental services received by the Covered Person for a condition. The term Course of Treatment does not include the diagnosing exam, x-rays or prophylaxis.

2. Emergency Care means dental services required on an immediate basis because any delay would cause the Covered Person to endure significant physical discomfort or substantially aggravate the condition for which these services are required.

SECTION 8

PRESCRIPTION BENEFITS

NOTE: You are eligible for Prescription Benefits only if you have Level 1, 2 or 3 Benefits and you elected the Indemnity Plan.

If you selected the Kaiser Plan, your prescription benefits are provided by Kaiser directly and your benefits are described in a separate booklet provided by Kaiser.

Prescription drug means a drug requiring, and obtainable only through, the written prescription of a licensed physician.

This Plan does not cover the following drugs or medications, even with a prescription:

- drugs to treat infertility
- drugs to treat non-disabling obesity, unless FDA approved to treat obesity under that Participant's particular circumstance
- drugs primarily used for cosmetic purposes
- retin-A
- growth hormones
- nutritional supplements, vitamins, or appetite suppressants

Only prescriptions filled through the Optum Rx program are covered.

Ask your doctor to prescribe generic drugs instead of brand name drugs whenever possible. It can result in savings to both you and the Plan.

Optum Rx Card

In order to have your covered prescriptions filled and paid by this Plan, you must present your Optum Rx card at a participating pharmacy.

The participating pharmacy will fill your prescription and provide you with-up to a 30-day supply of medication. You will be charged 20% of the discounted cost of the prescription.

The cost of the prescription will be based on a discount negotiated by Optum Rx based on the cost of generic drugs whenever appropriate.

If you have any questions or need help in locating a participating pharmacy, call (800) 797-9791 or go to www.optumrx.com.

A prescription may be refilled twice at a walk-in pharmacy. Subsequent refills must be done through the mail order program described below.

Optum Rx Mail Order

This is a program designed to provide further savings for maintenance-type prescription drugs through a mail order program. This program also allows you to purchase up to a 90-day supply of a prescription drug.

To use this program, obtain a Mail Service Prescription Drug Program form and follow the directions on the form.

Optum Rx will fill your prescription and provide you with up to a 90-day supply of the medication. You will be charged 10% of the discounted cost of the prescription.

The cost of the prescription will be based on a discount negotiated by the plan and will use generic drugs whenever appropriate.

In order for you to receive a 90-day supply, your doctor must prescribe a 90-day supply.

SECTION 9

EMPLOYEE ASSISTANCE PROGRAM: CLAREMONT EAP

The Trust Fund offers an employee assistance program (EAP) designed to assist eligible Participants with mental health and substance use disorder issues, in addition to the benefits the Fund offers for treatment of mental health and substance use disorder issues specified elsewhere in this Plan. It has contracted with Claremont EAP to coordinate the delivery of these types of services, as well as offer assistance with other issues including, but not limited to, family and financial counseling, basic legal matters, and child and elder care services.

Please call **Claremont EAP's toll-free number (800) 834-3773** to access these services and to get a referral to a provider who is appropriate for your needs. For more information about this program, please call the Trust Fund Office at (877) 572-7005.

Chemical Dependency Case Management Services

Claremont will provide chemical dependency case management services according to Plan allowances. Claremont services include connecting Participants to an appropriate facility, case management for up to 12 months and general support related to alcohol and drug abuse. Extended eligibility for substance abuse counseling and treatment is available only to the Employee and is available up to six (6) months after loss of Plan eligibility. As of January 1, 2015, Employees who were covered under the Kaiser plan and qualify for extended eligibility will receive benefits for substance abuse counseling and treatment services managed through Claremont under the Indemnity plan, at the same coverage Level that applied to the Kaiser coverage and subject to the $300-per-calendar year individual deductible.

In addition, Claremont EAP provides the following services for you and your eligible Dependents:

Counseling

Six free visits per incident, per family member (visits renew 12 months from date of intake). Counseling can address any personal issue such as marital/family conflicts, parenting concerns, substance abuse, work stress, depression, and other issues that affect your quality of life. Counseling is available in person or via video conference. Additional visits are offered to clients at Claremont's discounted rates.

Legal Consultation

Up to 30-minutes of free consultation is provided at no cost. A 25% discount is available for any service beyond the initial consultation. Telephonic or in-person consultation is available. Attorneys have expertise in areas such as family law, consumer issues, traffic violations and personal injury, etc. Free "Simple Will" kits are available upon request.

Financial Services

An initial 30-60 minute consultation with a financial counselor is available at no cost. Financial specialists are able to assist Employees and Dependents with budgeting, retirement planning, debt consolidation, ID theft, financial planning, auto and real estate purchasing, etc. Free credit reports and consultation are provided upon request.

Elder/Adult/Child Care

Nationwide referrals for elder/adult/child care resources are provided. A Work/Life Specialist consults with each Employee or Dependent member to generate a customized report, which provides a listing of appropriate agencies/services and other helpful written information.

School/College Assistance

This nationwide program helps parents research elementary and/or secondary schools for their child. Claremont also provides assistance with the college search process for both college-bound children and the working adult hoping to further his/her educational goals.

Adoption Assistance

Nationwide referrals for adoption attorneys, agencies, infertility specialists, and support groups are provided.

Convenience Referrals

Referrals provided for daily living such as pet care, home repair, errand services, travel, entertainment, and apartment locator services.

Wellness Referrals

Help with physician searches, medical support groups, fitness centers, diet & nutrition resources, alternative medicine, and other resources.

Claremont Personal Advantage (CPA)

Unlimited access is provided to Claremont's Enhanced Web Site for articles, resources, videos and assessments about health, finance, legal issues, personal growth, stress, family life and more.

Go to https://claremonteap.personaladvantage.com/.

Use the following company name: Local 831.

SECTION 10

EXCLUSIONS AND LIMITATIONS UNDER THE MEDICAL PLAN

This Plan will not pay benefits for or give credit for expenses that are not covered expenses or that are not Medically Necessary. Nor will this Plan pay benefits for or give credit for any expense if the confinement, service, or supply is:

1. for sickness or injury due to war or act of war, declared or undeclared, occurring while the person is covered by this Plan;

2. due to sickness or injury arising in the course of employment;

3. furnished by or on behalf of any government, unless payment of the charge is legally required, or mandated by the employer;

4. one for which charge would not have been made in the absence of coverage, or for which the covered person is not legally liable;

5. furnished in connection with any special education or training, including speech therapy and myofascial therapy, except as defined under "Rehabilitative Care";

6 for cosmetic purposes, except for Treatment of

   a. an injury, with Treatment started by a Physician within 6 months after the accident;

   b. a congenital birth defect or abnormality for functional repair or restoration of any body part when necessary to achieve normal body functioning; and

   c. reconstructive breast surgery, mastectomy, or lumpectomy, if the surgery is being performed due to disease, illness, or injury;

7. unless otherwise indicated, furnished for fitting or cost of eye glasses, contact lenses or hearing aids, except:

   a. when due to an injury to the natural eye or ear; or

   b. for the initial contact lens or pair of glasses after cataract surgery without intraocular lens implant;

8. unless otherwise indicated, for eye exams; vision analysis, non-surgical therapy or training relating to muscular imbalance of the eye, orthoptics except when performed to prevent surgery, radial keratotomy or surgical correction of refractive errors;

9. unless otherwise indicated, for dental Treatment of any kind, except when:

   a. Medically Necessary to correct damage to sound natural teeth caused by an injury and Treatment by a Physician is started within 90 days after the accident; or

   b. Medically Necessary for extraction of impacted (unerupted) third molars (wisdom teeth) unless the covered person is eligible for benefits under a dental plan.

   There is no coverage for Hospital care for Dental Treatment.

10. in excess of the Usual, Customary and Reasonable (UCR) charge, as determined by the Trustees:

11. for Treatment of Temporomandibular Joint (T.M.J.) Dysfunction or Myofascial Pain Dysfunction (M.P.D.);

12. for upper or lower jaw augmentation or reduction procedures (orthognathic surgery);

13. for treatment for weight control, such as:

   a. any treatment intended to result in weight loss;

   b. treatment for non-disabling obesity including surgery and complications therefrom;

14. for the following foot care procedures:

   a. trimming of nails, corns and calluses (except the removal of nail roots and necessary services in the treatment of metabolic or peripheral vascular disease);

   b. routine hygienic care;

   c. services and supplies for fallen arches or flat feet;

15. experimental, investigational, or educational;

16. for reproductive and sexual disorders and defects, whether or not the consequence of illness, disease, or injury including, but not limited to:

   a. impotency, including implants (except Erectile Dysfunction Drugs, such as Viagra)*;

      *The Plan will cover all Erectile Dysfunction Drugs (e.g., Sildenafil, Viagra) with a limit of 6 pills per month. All requests for "daily use"

dosages will be subject to medical necessity and to Optum's Pre-Authorization Program.

b. frigidity;

c. infertility;

d. reversal of sterilization;

e. artificial insemination;

f. in-vitro fertilization;

g. sex change operations; and

h. genetic testing or counseling;

17. for the following:

a. sexual counseling

b. vocational counseling;

c. outreach; and

d. job training;

Some of the above services may be covered under the Claremont Employee Assistance Program (EAP). See Section 9 above.

18. for Custodial or Maintenance care;

19. for communications, transportation, or travel time, except for ground and air ambulance service, which are covered based on medical necessity.

20. for maternity charges for Dependents other than your covered Dependent spouse.

21. for hospital or other charges for wellness care delivered to a patient or newborn except at a PPO facility where the charges for wellness care are included in the negotiated PPO rate. Wellness care includes, but is not limited to, charges made for care delivered which is not necessary to diagnose or treat an illness, injury or other condition requiring medical attention. It also includes any type of health education classes and materials.

22. for hospital charges for newborn care except for facility services at a PPO facility where the newborn baby's charges are part of the negotiated rate.

23. Non-emergency services outside the U.S.A.

24. for expenses incurred as a result of or during the claimant's commission of a felony.

25. for taxes or surcharges of any kind.

Items or services not listed elsewhere in this SPD as covered are excluded from coverage.

SECTION 11

COORDINATION OF BENEFITS

Definitions

For purposes of this Section 11:

1. "plan" means a plan providing benefits or services for or because of medical or dental care through:

    a. group or blanket coverage;

    b. group Anthem Blue Cross, group Blue Shield, group practice, and other group prepayment coverage;

    c. coverage under labor-management trusteed plans, union welfare plans, employer organization plans, or employee benefit plans;

    d. coverage under a government program or required by or provided under any statute, unless excluded from coverage under this plan; or

    e. automobile no-fault coverage and/or uninsured motorist where applicable.

    "plan" also means each part of a plan if:

    a. part of a plan coordinates its benefits; and

    b. part does not.

    "plan" does not mean an individual policy.

2. "Allowable Expense" means an expense which:

    a. is wholly or partly covered under any plan, including this Plan; and

    b. is Usual, Customary and Reasonable (UCR) as determined by this Plan.

    c. is Medically Necessary,

Effect on Benefits

1. This Plan will coordinate benefits with all other plans under which a covered person is eligible for benefits if the Allowable Expense is less than the sum of:

    a. the benefits provided by this Plan; and

    b. the benefits provided by other plans.

2. Except as provided in paragraph 3 below, this Plan will reduce its benefits so that the sum of the benefits provided by this Plan and the benefits provided by other plans do not exceed the total Allowable Expense.

3. This Plan will not reduce its benefits if:

   a. the following rules would require the other plan to:

      (1) coordinate benefits with this Plan; and
      (2) determine benefits after this Plan; and

   b. the following rules require this Plan to determine its benefits first.

4. The order for benefit determination is:

   a. a plan covering an individual as an Employee is primary to a plan covering that individual as a Dependent, except that if a plan is one covering retirees, and it provides that its benefits will be determined before this Plan, that provision will be controlling;

   b. The benefits of the policy or plan of the parent whose birthday, excluding year of birth, falls earlier in a year are determined before those of the policy or plan of the parent whose birthday, excluding year of birth, falls later in that year;

   c. If parents are separated or divorced;

      (1) If there is a court decree, whereby only one parent is responsible for the health care expenses of the child(ren), the expenses are paid according to the decree.
      (2) If there is no decree, the plan of the parent with custody pays first; the spouse of the parent with custody pays second; and the plan of the parent without custody pays last.

   d. when the above rules do not establish an order, benefits are determined first under the plan that covered the person for the longest period of time.

5. A reduction in benefits will be pro-rated for all covered expenses.

Exchange of Information

This Plan and other plans may exchange information needed in order to coordinate benefits. Covered persons must furnish needed information. The Plan has the right to withhold payment of claims until such information is provided.

Payment to Other Plans

If this Plan reimburses other plans for payments that should have been made under this Plan, those payments will be treated as benefits paid under this Plan.

Recovery

If, because of this provision, this Plan has overpaid benefits, it may recover the overpayment from the payee, from the Covered Person who benefited from the overpayment, from benefits due any family member of the payee, or from the other plan. By accepting payments from this Plan, each Covered Person hereby assigns to this Plan the Covered Person's claims against other plans, to the extent of the overpayment.

Medicare

For a non-retired person who is eligible for Medicare because of age or disability, the benefits of this Plan will be paid without reduction for any benefits payable under Medicare. For a person who becomes eligible for Medicare because of end stage renal disease, the benefits of this Plan will be paid without reduction for any benefits payable under Medicare for the first 30 months of eligibility and will thereafter be paid on a secondary basis under the terms of this Coordination of Benefits provision.

SECTION 12 EMPLOYEE ELIGIBILITY PROVISIONS

For information on Dependent eligibility, see SECTION 13.

ELIGIBLE CLASSES OF EMPLOYEES

When you work in covered employment for an employer that is a signatory to a labor agreement with Trade Show & Sign Crafts Local Union 831, contributions should be made to this Plan on your behalf. These contributions are used to determine eligibility for you and your Dependents.

Some employers contribute a set amount to this Plan for each hour you work in covered employment; others contribute a fixed amount per month if you work the required number of hours or days in a month.

APPLICATION FORM FOR EMPLOYEE COVERAGE

In order to obtain coverage, you must fill out the enrollment form provided by the Trust Fund Office. To be eligible for coverage, a Dependent must be listed on the enrollment form. Proof of Dependent status must be provided to the Trust Fund Office.

- For a Dependent legal spouse - submission of a certified copy of a marriage certificate.
- For natural unmarried children - submission of a certified copy of a birth certificate.
- For stepchildren - submission of a certified copy of a birth certificate, a certified copy of a marriage certificate, and a completed stepchild declaration which may be obtained from the Trust Fund Office.
- For adopted children - submission of a certified copy of a birth certificate and adoption decree.
- For a grandchild - submission of a certified copy of the Court Order showing legal custody in the Employee's name, or, if custody is in the Employee's spouse's name, a certified copy of a marriage certificate and an affidavit of full support, together with the Court Order showing legal custody in the spouse.
- Same sex spouse or a registered domestic partner – submission of a certified copy of a marriage certificate or state of California certificate of domestic partnership (or other proof of registration of domestic partnership).

METHOD OF GAINING ELIGIBILITY

If your employer contributes on a per-hour basis, all hours contributed for you are used to calculate Benefit Credits. If you have sufficient Benefit Credits, they are then used to provide for your monthly coverage. Credits earned above the amount needed to provide

for your selected level of coverage on a monthly basis are banked as Reserved Benefit Credits, as described in more detail below.

If your employer contributes a fixed amount per month, you will be assigned to the Level of Coverage that is appropriate for that contribution.

You can correct any difference between the hours you have worked and the contribution your employer has made towards your benefits, by submitting your check stubs to the Trust Fund Office.

LEVEL SELECTION

You must pre-select one of the four Plan levels offered (unless assigned due to a fixed employer contribution under your collective bargaining agreement).

The first three Plan levels have the same major medical benefit options, e.g., an Indemnity Plan or Kaiser (an HMO). The important differences in the first three Plan levels are the amount of Dental coverage provided and the availability of Vision and Prescription benefits. While the Level 4 plan also has a choice of Kaiser or an Indemnity Plan, the coverage is less comprehensive. (See Section 3, "SCHEDULE OF COVERAGE".)

Each Plan level requires a specific number of Benefit Credits earned through hours worked. Credits can be earned in the qualifying month or drawn from your Reserve Benefit Credits as described below.

Know the Plan rules - your coverage may depend on it.

Read this section carefully to help you make an informed selection. If you choose a level that you cannot support because you do not work enough hours, you may lose coverage. (See the "Schedule of Hours").

If you do not make a selection, you will automatically be assigned to Plan Level 4.

Selecting Your Plan Level

If you are a new employee or if you previously lost eligibility and have now returned to work, you **must choose** the level of coverage you believe you can maintain throughout the year. You must calculate or estimate the total number of hours you will work in the coming one-year period.

Regardless of the number of hours you work, in order to be covered by Level 1, 2 or 3, you must actively select the coverage level you want by completing, signing and submitting the enrollment form. *If you do not submit an enrollment form, you will automatically be assigned Level 4.*

Once you have enrolled in a plan level, that plan level will remain in effect for as long as you remain eligible for coverage. Only if you wish to change your level of coverage will you need to submit additional forms to the Trust Fund Office.

Your Benefit Credits are your hours worked multiplied by your hourly contribution rate. The hourly contribution rate is determined by the collective bargaining agreement that covers that work. The chart below shows the number of hours per month required for the different levels of coverage, for the contribution rate of $12.90 (the contribution rate effective for most agreements as of September 1, 2023).

Schedule of Hours

	Level 1	Level 2	Level 3	Level 4
Hours Needed @ $12.90 rate	140	120	100	80
Benefit Credits Required	1,806	1,548	1,290	1,032
Maximum "Bank"	9,030	7,740	6,450	5,160

Example

If you are already an eligible employee and select level 1 (1,806 Benefit Credits per month) and work 150 hours in October at $12.90 per hour, that 150 hours x $12.90 per hour earns you 1,935 Benefit Credits. 1,806 of your Benefit Credits are used for your coverage in December. This leaves you with 129 Benefit Credits added to your Bank.

These hour requirements and contribution rates will change. Current information can be obtained from the Trust Fund Office by calling (877) 572-7005 or (626) 279-3080.

Date Employee Becomes Eligible For Coverage

If you are a new employee, or if you previously lost eligibility, you will generally become eligible for Employee coverage on the first day of the fifth month of a period that begins with three continuous months during which you average the minimum hours for the coverage level that you have selected, so long as you are credited with at least 25 hours in the first month. Eligibility conditions may vary depending on the relevant CBA. See your CBA for more details.

Example

If you select Level 1 coverage and accumulate an average of at least 1,806 Benefit Credits per month for three consecutive months:

January	1,505 Benefit Credits
February	1,956 Benefit Credits
March	2,002 Benefit Credits

April	"Lag month" or the month in which the Trust Fund Office first knows that you have enough Benefit Credits to become eligible.
May	You become eligible on May 1.

If you previously lost eligibility, have returned to Covered Employment, and had any Reserve Benefit Credits in your Bank (as explained in more detail below), when contributions for your current employment are added to your Bank and are sufficient for a month of coverage, your coverage will be reinstated as of the second month following such employment.

Example

If you select level 1 (1,806 Benefit Credits per month) and work 120 hours in October at $12.90 per hour, that 120 hours x $12.90 per hour earns you 1,548 Benefit Credits. You also have 536 Reserve Benefit Credits in your Bank from before you lost eligibility. 1,548 of your Benefit Credits earned and 258 Reserve Benefit Credits are used for your coverage in December. This leaves you with 278 Reserve Benefit Credits in your Bank.

Banking of Hours and Reserve Benefit Credits

The Bank enables you to accumulate Reserve Benefit Credits during peak work periods, and then use the Reserve Benefit Credits to fund your medical coverage during non-peak periods of work. You also may continue coverage on a self-pay basis (as described below), or under COBRA if you qualify to do so. For more information on COBRA, see SECTION 14, "CONTINUATION COVERAGE RIGHTS UNDER COBRA".

If you work more hours than are necessary to earn the Benefit Credits required for the level of coverage you have selected, you will accumulate Reserve Benefit Credits in the Bank. These Reserve Benefit Credits will be used if you don't otherwise have enough work hours to maintain eligibility until there are insufficient Benefit Credits remaining in your Bank to use for a month's eligibility. At that time your active coverage will be cancelled unless you elect to go to a lower Level of Coverage for which you do have enough hours.

Certain limitations apply to the Bank:

1. You may accumulate up to a maximum of five months of Reserve Benefit Credits for the Level of Coverage you have elected in the Bank at any given time. Once you have accumulated five months of Reserve Benefit Credits for the Level of Coverage you have elected, you will not be able to accumulate more Reserve Benefit Credits in the Bank until after you have used some or all of the Reserve Benefit Credits you have already accumulated or you switch to a higher Level of Coverage.

2. If you do not have sufficient Benefit Credits for a month's eligibility, and thus would otherwise lose Plan coverage, you may drop down to a lower level of coverage, if applicable, or self-pay the full cost for that month.

   In addition, if you, through COBRA, maintain the full package of benefits in which you participated immediately before your COBRA "Qualifying Event," any Reserve Benefit Credits in your Bank will be carried forward for a maximum of six months. Any hours you work during that 6-month period will be added to your hour bank helping you to regain eligibility under the Bank rules above. In the event you do not accumulate the hours required to regain eligibility within the 6-month period, you will lose the remaining Reserve Benefit Credits in your Bank.* However, your COBRA rights will continue.

3. If you become inactive, unused Reserve Benefit Credits will be used to pay for coverage at your selected level. When you do not have enough credits to pay for your selected level of coverage you will become ineligible. Any credit balance left once you become ineligible may be carried forward for 6 months. In the event you do not accumulate the hours required to regain eligibility within the 6-month period, you will lose the remaining Reserve Benefit Credits in your Bank.*

   *Effective December 1, 2021, and until further notice, a Participant who was (a) eligible for benefits on April 1, 2020 or (b) had any benefits credits on April 1, 2020 following the reinstatement of forfeited benefit credits, will not lose any remaining Reserve Benefit Credits in these circumstances and that Participant's Bank will not be able to drop below one Benefit Credit.

   Effective October 1, 2023, a Participant who meets the above criteria may elect in writing to the Trust Fund Office to decline these rules such that their Bank will be allowed to drop below one Benefit credit and their Reserve Benefit Credits allowed to be forfeited should they have an insufficient number of credits to regain eligibility during any 6-month period. Such election will be effective until revoked, and such revocation will become effective on the first day of the second month following the month that the Trust Fund Office receives the Participant's notice to the Board of Trustees of such revocation.

Note: Benefit Credits and the Bank may only be used in connection with the benefits provided by this Plan. Benefit Credits have no other value.

RIGHT TO SELF-PAY/BUY UP OPTION

If you have met the standards for initial qualification and are eligible for coverage, the self-pay/buy-up option may be available to you. This option allows you to maintain coverage when you do not have enough Benefit Credits through hours worked or Reserve Benefit Credits banked to pay for coverage for the next month. If you do not use this option, your

coverage will be terminated, unless you elect coverage provided through COBRA (see SECTION 14 "CONTINUATION COVERAGE RIGHTS UNDER COBRA").

Self-payment must be made to the Trust Fund Office prior to the month for which coverage is desired and is limited to a six consecutive month period.

Self-Pay/Buy-Up Option

If you do not earn enough Benefit Credits through hours worked or do not have enough Reserve Benefit Credits in the Bank for your Level of Coverage, you may purchase up to 50% of your required hours to continue your eligibility. You must have at least 50% of the Benefit Credits required for the Level of Coverage you have selected. Upon losing coverage, you will receive notice from the Trust Fund Office on the Self-Pay/Buy-Up option with your COBRA notice. Self-payment must be received by the Trust Fund Office by the end of the month in which you receive the notice and prior to the month for which coverage is desired.

Example

An Employee is covered under Plan Level 3. The Employee worked 50 hours in October, earning 645 (50 x 12.90) Benefit Credits, and has no Reserve Benefit Credits in the Bank. The required number of Benefit Credits for Plan Level 3 is 1,290. To make up the missing 645 hours, the Employee can pay $645 by the end of November to obtain December coverage.

EFFECTIVE DATE OF COVERAGE

Once you become eligible, you will be enrolled in the default plan (Indemnity Level 4). If you submit an enrollment form within 90 days of establishing eligibility, you will be enrolled in the Plan and Level selected (if no services have been rendered and the enrollment form is received prior to the 15th of the month, and if requested, the effective date will be the 1st of that month). If no request is made or the enrollment form is received after the 15th of the month, the effective date will be the 1st of the following month.

DATE EMPLOYEE COVERAGE ENDS

Your coverage will automatically end on the earliest of the following dates:

1. the date this Plan ends;

2. the date you become ineligible for coverage;

3. the date you begin active duty in the armed forces;

4. the date you fail to make a required premium contribution; or

5. 31 days after you have established residence outside the U.S. or Canada.

This Plan does not cover charges for conditions after eligibility terminates, even if those conditions developed or if treatment for those conditions began when you were eligible for coverage under this Plan. Any charges for dates of service after the date your eligibility terminates will not be covered.

The benefits under this Plan are not vested or guaranteed. They may be modified, reduced or canceled at any time by the Board of Trustees.

FAMILY MEDICAL LEAVE ACT

You may be entitled to have contributions made on your behalf while you are not working under the Family Medical Leave Act (FMLA). The FMLA entitles eligible Employees to take up to a maximum of 12 weeks of unpaid leave during any 12-month period for specified family or medical reasons, such as the birth of a child, child care for the Employee's children, the adoption of a child by the Employee, the need to care for a family member with a serious health condition, or the Employee's inability to perform the duties of his position due to a serious health condition.

You may also be entitled to up to a maximum of 12 weeks of unpaid leave because of a "qualifying exigency" (as defined in Department of Labor Regulations) arising out of the fact that your spouse, son, daughter or parent is on active duty, or has been notified of an impending call or order to active duty in the Armed Forces in support of a contingency operation. If you believe you are entitled to a leave due to a "qualifying exigency," you should contact your Employer.

In addition, the FMLA now permits a spouse, son, daughter, parent, or next of kin to take up to 26 work weeks of leave (including any other FMLA leave in the same 12-month period) to care for a member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recuperation, or therapy, is otherwise in outpatient status, or is otherwise on the temporary disability retired list, for a serious injury or illness.

Check with your employer to determine whether your Employer is subject to the FMLA and whether the leave you wish to take is covered by the FMLA. Your Employer has an obligation to continue your coverage under this Plan during a leave of absence that is covered by the FMLA. In order to continue your Plan coverage, your Employer must continue to make contributions on your behalf for any period that you are on approved FMLA leave. Please contact the Trust Fund Office if you intend to take FMLA leave so that we are aware of your Employer's obligation to make contributions during your absence. Note that if you do not return to work after your FMLA leave ends, you may be required to repay the amount your Employer paid to the Plan for your coverage while on leave.

EXTENSION OF COVERAGE DUE TO WORK-RELATED DISABILITY

An extension of coverage is available which will allow for up to 3 months of extended coverage if you become unable to work due to a work-related disability. Extended

coverage applies to non-work-related services for both the Participant and any Dependents. You may be eligible for this benefit if you meet all of the following three requirements:

(1) you are not eligible to receive an extension of coverage through your employer;

(2) you are eligible for health benefits under this Plan at the time you become unable to work; and

(3) you are unable to work due to a work-related disability.

All requests for extended coverage during a disability must be supported with the necessary documentation required by this Plan. For more information, contact the Trust Fund Office.

ROLLING ENROLLMENT

Under the twelve (12) month rolling enrollment provisions, once you have chosen your medical/dental plan, you may only change your medical/dental plan once every rolling twelve (12) month period from the date of your last change, provided you have participated in the same medical or dental plan for at least twelve (12) months. The change will be effective on the first of the month following your election. An exception to this twelve (12) month rule will be made if you have moved out of the service area of the medical/dental plan, which you have previously chosen. Another exception to the rule is if you want to lower your level of coverage, which you may do at any time.

When a Participant establishes eligibility, the Participant will be enrolled in the default Medical Plan, which is the Indemnity Plan Level 4. If the eligible Participant does not want to remain in the Indemnity Plan Level 4, **an Enrollment Form must be submitted within 90 days** after establishing eligibility. Once the individual selects the desired Medical Plan and the Plan Level, they are bound for the next 12 months. They also will not be able to improve their Level of Coverage for that same 12 months, though they can lower the Plan Level during the year as many times as needed. A Participant can only select a higher Plan Level after being enrolled in their initial or current Plan Level for at least 12 consecutive months. An Enrollment Form must be submitted each time for any Plan Level change. The Plan Level change will not be done automatically. If the Participant does not have sufficient credits to remain eligible at the Plan Level selected, and the Participant fails to affirmatively elect a lower level, the Participant will lose coverage. The Plan Level change will not be granted if requested after coverage is terminated.

Example: Suppose you enroll in a plan on January 1, 2024. Fifteen months later, on April 1, 2025, you want to change plans. You no longer have to wait until the end-of-the-year open enrollment period. Now, because you have been enrolled in the same plan for more than 12 consecutive months, you can file a new Enrollment Form to have your plan changed as of May 1, 2025.

If you are already enrolled in the Fund and you do not want to make any changes to your current coverage, and if the information on your Health Enrollment Form currently on file

with the Trust Fund Office is accurate, you do not need to submit an Enrollment/Change Form.

If you want to initially enroll in the Fund, or make any changes and you have been enrolled in the current Plan for at least twelve (12) consecutive months (such as switching between the Indemnity Plan and the Kaiser Plan or adding/removing dependents), you must submit an Enrollment/Change Form to the Trust Fund Office. You can contact the Trust Fund Office at 626.279.3080 or 1.877.572.7005 and request that an Enrollment Form be mailed to you.

SWITCHING TO A LOWER LEVEL OF COVERAGE

You may switch to a lower level of coverage at any time. To do this, you must provide the Trust Fund Office with notice in writing at least 30 days before the first day of the month for which the change is to become effective.

Once you change to a lower level of coverage, you may not move back up to a higher level of coverage until the end of the twelve month "rolling enrollment" period described above.

SWITCHING TO A HIGHER LEVEL OF COVERAGE

You may switch to a higher level of coverage after being enrolled in your initial or current Plan Level for at least 12 consecutive months. An Enrollment Form must be submitted selecting the new Plan Level at least 30 days before the new eligibility month.

SECTION 13

DEPENDENT ELIGIBILITY PROVISIONS

NOTE: See SECTION 18 for the definition of "Dependent".

DATE DEPENDENT BECOMES ELIGIBLE FOR COVERAGE

Your Dependent becomes eligible for coverage on the later of:

1. the date you become eligible; or

2. the date the individual meets the qualifications as set out under the definition of Dependent.

You must apply in writing for Dependent coverage. Application must be made on an enrollment form.

DATE DEPENDENT COVERAGE BECOMES EFFECTIVE

Dependent coverage will become effective on the latest of the following:

1. the date you apply for Dependent coverage;

2. the date your coverage becomes effective;

3. the date the person becomes an eligible Dependent.

DATE COVERAGE OF A NEWBORN DEPENDENT BECOMES EFFECTIVE

If you are then eligible, coverage is effective for your newborn child for 31 days from the moment of birth. Coverage will continue beyond 31 days only if you apply for Dependent coverage before the end of the 31-day period.

DATE DEPENDENT COVERAGE ENDS

Dependent coverage will end on the earliest of the following dates:

1. the date this Plan ends;

2. the date you become ineligible;

3. the date you fail to make a required premium contribution;

4. the date your coverage ends;

5. the date the Dependent commences active duty in the armed forces;

6. the date the person ceases to be a Dependent; or

7. 31 days after the Dependent establishes residence outside the U.S.

SPECIAL ENROLLMENT

If you are an active Employee in the Plan and your eligible Dependent(s) previously declined enrollment in the Plan because of other health insurance coverage, you may be able to enroll yourself or your eligible Dependents prior to the next Open Enrollment period if the other coverage is lost. If you or your eligible Dependent(s) had COBRA coverage under another plan at the time you declined coverage and that coverage has now been exhausted, you may request that you and your eligible Dependent(s) be enrolled in this Plan. In addition, if you or your eligible Dependent(s) had other coverage (not COBRA coverage) at the time you declined enrollment and the other coverage is terminated either because of a loss of eligibility for coverage (due to legal separation, divorce, death, termination of employment, reduction in the number of hours of employment) or because the other employer stopped contributing for the other coverage, you may request that you and/or your eligible Dependent(s) be enrolled in the Plan. In any of these cases, requests for enrollment must be in writing and sent to the Plan within 30 days after the other coverage is terminated or employer contributions towards the other coverage are terminated. If a completed request for enrollment is received within the 30-day period, you and your eligible Dependent(s) will be enrolled in the Plan as of the first day of the month following the date a completed request for enrollment is received.

If you are eligible to participate in the Plan and you previously declined enrollment in the Plan for any reason, and you have now acquired a new eligible Dependent (as defined by the Plan) through marriage, birth, adoption, or placement for adoption, you may be able to enroll yourself (and therefore that Dependent) in the Plan without waiting until the next Open Enrollment period. In order to enroll yourself in the Plan under these circumstances, send a written request for enrollment to the Trust Fund Office within 30 days of the date of the marriage, birth, adoption, or placement for adoption.

If you are an Employee and you acquire a new spouse or a new eligible Dependent through birth, adoption, or placement for adoption, you may be able to enroll your new spouse or eligible Dependent in the Plan. In order to enroll under these circumstances, submit an enrollment form to the Trust Fund Office within 30 days of your acquisition of the new Dependent (that is, the date of the marriage, birth, adoption, or placement for adoption). In the case of a marriage, the Plan coverage for your new spouse will be effective on the date of the marriage. In the case of a birth, adoption, or placement for adoption for your new child, the Plan coverage for your child will be effective on the date of the birth, adoption, or placement for adoption. All effective dates are subject to the Trust Fund Office's receiving a completed enrollment form.

SECTION 14

CONTINUATION COVERAGE RIGHTS UNDER COBRA

This Section has important information about your right to COBRA continuation coverage, which is a temporary extension of coverage under this Plan. **This notice explains COBRA continuation coverage, when it may become available to you and your family, and what you need to do to protect your right to get it.** When you become eligible for COBRA, you may also become eligible for other coverage options that may cost less than COBRA continuation coverage.

The right to COBRA continuation coverage was created by a federal law, the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). COBRA continuation coverage can become available to you and other members of your family when group health coverage would otherwise end. For more information about your rights and obligations under the Plan and under federal law, you should review this Summary Plan Description or contact the Trust Fund Office.

What is COBRA continuation coverage?

COBRA continuation coverage is a continuation of Plan coverage when it would otherwise end because of a life event. This is also called a "qualifying event." Specific qualifying events are listed later in this notice. After a qualifying event, COBRA continuation coverage must be offered to each person who is a "qualified beneficiary." You, your spouse, and your Dependent children could become qualified beneficiaries if coverage under the Plan is lost because of the qualifying event. Under this Plan, qualified beneficiaries who elect COBRA continuation coverage must pay for COBRA continuation coverage.

If you're an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your hours of employment are reduced, or
- Your employment ends for any reason other than your gross misconduct.

If you're the spouse of an Employee, you'll become a qualified beneficiary if you lose your coverage under the Plan because of the following qualifying events:

- Your spouse dies;
- Your spouse's hours of employment are reduced;
- Your spouse's employment ends for any reason other than his or her gross misconduct;
- Your spouse becomes entitled to Medicare benefits (under Part A, Part B, or both); or
- You become divorced or legally separated from your spouse.

Your Dependent children will become qualified beneficiaries if they lose coverage under this Plan because of the following qualifying events:

- The parent-Employee dies;
- The parent-Employee's hours of employment are reduced;
- The parent-Employee's employment ends for any reason other than his or her gross misconduct;
- The parent-Employee becomes entitled to Medicare benefits (Part A, Part B, or both);
- The parents become divorced or legally separated; or
- The child stops being eligible for coverage under the Plan as a "Dependent child."

When is COBRA continuation coverage available?

The Plan will offer COBRA continuation coverage to qualified beneficiaries only after the Trust Fund Office has been notified that a qualifying event has occurred. The employer must notify the Trust Fund Office of the following qualifying events:

- The end of employment or reduction of hours of employment;
- Death of the Employee;
- The Employee's becoming entitled to Medicare benefits (under Part A, Part B, or both).

For all other qualifying events (divorce or legal separation of the Employee and spouse or a Dependent child's losing eligibility for coverage as a Dependent child), you must notify the Trust Fund Office within 60 days after the qualifying event occurs. You must provide this notice to the Trust Fund Office at P.O. Box 3118, Covina, California 91722-9118.

How is COBRA continuation coverage provided?

Once the Plan Administrator receives notice that a qualifying event has occurred, COBRA continuation coverage will be offered to each of the qualified beneficiaries. Each qualified beneficiary will have an independent right to elect COBRA continuation coverage. Covered Employees may elect COBRA continuation coverage on behalf of their spouses, and parents may elect COBRA continuation coverage on behalf of their children.

COBRA continuation coverage is a temporary continuation of coverage that generally lasts for 18 months due to employment termination or reduction of hours of work. Certain

qualifying events, or a second qualifying event during the initial period of coverage, may permit a beneficiary to receive a maximum of 36 months of coverage.

There are also ways in which this 18-month period of COBRA continuation coverage can be extended:

Disability extension of 18-month period of COBRA continuation coverage

If you or anyone in your family covered under the Plan is determined by Social Security Administration (SSA) to be disabled and you notify the Plan Administrator in a timely fashion, you and your entire family may be entitled to get up to an additional 11 months of COBRA continuation coverage, for a maximum of 29 months. The disability would have to have started at some time before the 60th day of COBRA continuation coverage and must last at least until the end of the 18-month period of COBRA continuation coverage. You must notify the Trust Fund Office in writing of your disability and SSA determination within 60 days of the SSA determination and before the end of the first 18 months of your continuation coverage. Each qualified beneficiary who has elected continuation coverage will be entitled to the 11-month disability extension if one of them qualifies. If the qualified beneficiary is determined to no longer be disabled under the SSA, you must notify the Plan in writing of that fact within 30 days after that determination. Notifications should be mailed to the Trust Fund Office at P.O. Box 3118, Covina, California 91722-9118.

Second qualifying event extension of 18-month period of continuation coverage

If your family experiences another qualifying event during the 18 months of COBRA continuation coverage, the spouse and Dependent children in your family can get up to 18 additional months of COBRA continuation coverage, for a maximum of 36 months, if the Plan is properly notified about the second qualifying event. This extension may be available to the spouse and any Dependent children getting COBRA continuation coverage if the Employee or former Employee dies; becomes entitled to Medicare benefits (under Part A, Part B, or both); gets divorced or legally separated; or if the Dependent child stops being eligible under the Plan as a Dependent child. This extension is only available if the second qualifying event would have caused the spouse or Dependent child to lose coverage under the Plan had the first qualifying event not occurred.

Are there other coverage options besides COBRA Continuation Coverage?

Yes. Instead of enrolling in COBRA continuation coverage, there may be other coverage options for you and your family through the Health Insurance Marketplace, Medicaid, or other group health plan coverage options (such as a spouse's plan) through what is called a "special enrollment period." Some of these options may cost less than COBRA continuation coverage. You can learn more about many of these options at www.healthcare.gov.

Cal-COBRA:

If at the time of a qualifying event your medical and prescription drug coverage is provided through a health maintenance organization (HMO), your coverage which would otherwise end under federal law may be required to be extended by the HMO to a total of 36 months under California law. You must contact the HMO directly and immediately upon the expiration of your federal COBRA coverage to obtain eligibility information for Cal-COBRA and how to apply for it.

If you have questions:

Questions concerning this Plan or your COBRA continuation coverage rights should be addressed to the contact or contacts identified below. For more information about your rights under the Employee Retirement Income Security Act (ERISA), including COBRA, the Patient Protection and Affordable Care Act, and other laws affecting group health plans, contact the nearest Regional or District Office of the U.S. Department of Labor's Employee Benefits Security Administration (EBSA) in your area or visit www.dol.gov/ebsa. (Addresses and phone numbers of Regional and District EBSA Offices are available through EBSA's website.) For more information about the Marketplace, visit www.HealthCare.gov.

Keep your Plan informed of address changes

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

Plan contact information

Trust Fund Office at P.O. Box 3118, Covina, California 91722-9118, (877) 572-7005 or (626) 279-3080.

SECTION 15

RETIREE ELIGIBILITY PROVISIONS

RETIREMENT ON JANUARY 1, 2007 OR LATER

If you retired on or after January 1, 2007, you are eligible for retiree benefits under this Plan (referred to herein as "Retiree COBRA") if on the date of your Actual Retirement (if before age 65), you meet each of the following special qualifications:

1. You had been an Active Employee in this Plan for at least 12 of the immediately preceding 24 months (excludes time on any COBRA coverage); provided, however, that:

    a. if you retired during 2021, you would meet this requirement if you had been an Active Employee in this Plan for at least 12 of the immediately preceding 36 months (excludes COBRA coverage); and

    b. if you retired during 2022, you would meet this requirement if you had been an Active Employee in this Plan for at least 12 of the immediately preceding 48 months (excludes COBRA coverage)

and

2. You had been, at the time of retirement, either:

    a. credited with at least ten (10) full years of Vesting Service in the Southern California Local 831 Employer Pension Plan within the immediately preceding fifteen (15) years (or sixteen (16) years if you retired in 2021; seventeen (17) years if you retired in 2022), or

    b. credited by this Plan with at least 1,000 hours of Covered Employment in at least ten (10) Plan Years within the immediately preceding fifteen (15) Plan Years (or sixteen (16) years if you retired in 2021; seventeen (17) years if you retired in 2022).

During the period of Retiree COBRA coverage – and only during that period – the term "Employee," as used throughout this Plan, will apply to retirees covered by Retiree COBRA.

If you are a Retiree (or the surviving spouse of a Retiree) receiving a monthly benefit from the Southern California Local 831 Employer Pension Plan (the "Local 831 Pension Plan"), you must then sign an authorization that your premium for Retiree COBRA will be paid via a deduction from your Local 831 Pension Plan monthly pension benefit. This deduction for Retiree COBRA from your Local 831 Pension monthly pension benefit will be automatically forwarded to the Trust Fund Office. Otherwise, without this mandatory deduction to pay your monthly premium for Retiree COBRA, you will not be eligible to enroll and/or continue to receive Retiree COBRA coverage.

Please note that your assignment to pay your Retiree COBRA premium via an automatic deduction from your Local 831 Pension Plan monthly benefit is *revocable at any time by you*; provided, however, that if and when you revoke your pension assignment to pay your Retiree COBRA premium, you will no longer be eligible for Retiree COBRA coverage.

Please contact the Trust Fund Office for Local 831 Pension Plan for the required assignment forms.

Health Plan Suspension Rule

If you are eligible for another group's health plan coverage by reason of your employment, or as a dependent in the event of your spouse's employment, you may suspend your coverage under this Plan and your obligation to make premiums by giving appropriate written notice to the Plan Administrator. You will then be again eligible under this Plan on the first of the month following the date your eligibility under the other group's health plan ends, provided you tell us within 31 days of the date you are no longer eligible to be covered under the other group health plan. Your coverage and premium under this Plan will be re-instated on the first of the month immediately following the last month in which you were eligible under the other group's health plan, provided you timely notify the Trust Fund Office of the termination of your eligibility under the other group health plan. If you do not notify the Trust Fund Office within 31 days of the termination of the other coverage, coverage under this Plan will be prospective from the first of the month next following your notice. However, the Trustees may provide retroactive coverage where the beneficiary could not reasonably provide timely notice. Even where the beneficiary could not reasonably provide timely notice, if notice is not provided within six months after termination of the other coverage, your right to be reinstated in the Plan will be on a prospective basis only.

Health Plan Subsidy for Years of Credited Service Coverage

If you are receiving Retiree COBRA benefits, then you will receive a subsidy of $20 per month times the greater of your full years (1650 hours) of Benefit Service in the Southern California Local 831 Employer Pension Plan or your Years in this Plan in which you had at least 1,650 hours of Covered Employment.

The subsidy will only apply after the active bank has been depleted, such that there is either 1 or 0 Benefit Credits remaining in the Bank.

If you return to work after retirement and you work more than 40 hours during any one month in the same trade or craft and in the same geographical area as covered by the Plan, your pension benefit is suspended and your Health Plan subsidy for that month will also be suspended.

If you have post-retirement work hours, employer contributions made towards Health coverage will be reviewed quarterly and if you have accumulated enough for at least one month of coverage for the level selected, including your Health Plan Subsidy, then you will be notified that no payment is necessary for specified months.

"Actual Retirement" means application for and continued receipt of retiree benefits from this Plan. Benefits under this Retiree COBRA Plan shall be prospective only from the time a valid and

payable application for pension benefits is filed. Benefits under this plan shall not be retroactive even if the pension benefits are retroactive.

Retiree COBRA supplements COBRA requirements by reducing the required COBRA premiums for the Employee and his or her Dependents who participate in the Retiree COBRA plan at the time of the Employee's first retirement and continues coverage for the Employee and his or her Dependents who participate in the Retiree COBRA plan at the time of your first retirement. After you have used up all of your regular COBRA Benefits, the Retiree COBRA Plan then continues your coverage and that of Dependents, if the same Dependents were covered for the entire period since your Actual Retirement. This coverage will continue until one of the events listed under Termination of Coverage occurs.

"Active Employee", for the purposes of this provision, means only those whose current participation in this Plan results from employer contributions, pursuant to a collective bargaining agreement, or participation agreement for current active employment. Such participation does not include things such as participation as a result of payments made under a collective bargaining agreement for persons not then currently actively employed, nor self-payments, nor participation from an extension of benefits for disability.

Dependent Coverage

If you met the eligibility requirements above and enrolled for retiree health benefits you may also enroll your Dependent children and your legal spouse as Dependents provided your Dependent children and your legal spouse are enrolled at the same time you enroll, were covered by the Plan as your Dependent Children and legal spouse while you were an Active Employee, and your legal spouse agrees, in writing, to select participation in Retiree COBRA instead of participation in COBRA and specifically waived participation in COBRA. You may not later add Dependent children or a legal spouse for coverage under Retiree COBRA even if you were not married at the time you enrolled in this Plan and subsequently married or you divorced and subsequently re-married.

Termination of Coverage

Your coverage will automatically end on the earliest of the following dates:

1. the date this Plan ends;

2. the date you become ineligible for coverage, including your failure to authorize an assignment of your premium from your Local 831 Pension Plan monthly benefit, or your revocation of a previous Local 831 Pension Plan monthly benefit assignment to pay your Retiree COBRA premium. If you lose eligibility due to non-payment or late payment of premiums, you will not be eligible for reinstatement even if you are subsequently re-hired and covered as an Active Employee and subsequently re-retire prior to when you turn age 65 (although you may still be entitled to regular COBRA Benefits);

3. the first of the month in which you turn age 65 or, if earlier, in which you become eligible for Medicare;

4. the date you begin active duty in the armed forces;

5. 31 days after you have established residence outside the U.S.;

6. the date retirees are no longer an eligible class under this Plan;

7. the date you become eligible for any other group medical coverage including but not limited to, coverage under another group plan, State or Federal programs such as Medicaid, Medicare, Social Security or Veterans Administration coverage; or

8. the date you are no longer actually retired.

Coverage for your Dependent(s) will end on the earliest of the following dates:

1. the date this Plan ends;

2. the date you become ineligible;

3. the first of the month in which your Dependent turns age 65 or, if earlier, becomes eligible for Medicare;

4. the date you fail to make a required premium contribution. If you are receiving a monthly benefit from the Local 831 Pension Plan, then you must pay your required premium contribution via a deduction from your Local 831 Pension Plan monthly benefit. Otherwise, without this mandatory deduction to pay your monthly premium for Retiree COBRA, you will not be eligible to enroll and/or continue to receive Retiree COBRA coverage. If you lose eligibility due to non-payment or late payment of premiums, your Dependent will not be eligible for reinstatement even if you are subsequently re-hired and covered as an Active Employee and subsequently re-retire prior to when you turn age 65 (although you may still be entitled to regular COBRA Benefits);

5. the date your coverage ends unless your coverage ends because you become entitled to Medicare before age 65. In such case, if your Dependents are entitled to additional regular COBRA after your coverage ends, the Retiree COBRA subsidy will continue to be paid until the earlier or (a) you reaching age 65 or (b) your Dependents are no longer entitled to regular COBRA;

6. the date the Employee or Dependent commences active duty in the armed forces;

7. the first of the month following your death;

8. the date the person ceases to be a Dependent; or

9. 31 days after the Dependent establishes residence outside the U.S.

Subsequent Return to Active Covered Employment

If you retired and are covered under the Retiree Health Plan and you subsequently return to covered employment, you and your Dependents will be eligible for the Active Health Plan on the same terms and conditions as applied to all other Active Employees (you will continue to be eligible as a retiree during the initial eligibility period if you meet the other conditions for retiree coverage).

If you are an under age 65 retiree and, after you return to covered employment, you again retire, you shall again become eligible for retiree health coverage for you and your eligible Dependents upon your subsequent re-retirement provided you have maintained continuous coverage under this Plan and meet the rules for retiree coverage in force at that time.

Enrollment Procedures

If you wish to enroll in Retiree COBRA, you must fully complete the required enrollment form and return it to the Trust Fund Office within 60 days of your retirement or the date which you first become eligible for Retiree COBRA, if different.

The Trust Fund Office will send Retiree COBRA information and the proper enrollment form to each Employee in this Plan for whom it has received notice of an upcoming scheduled retirement date.

Premiums, if any, for the Retiree COBRA extension period coverage are due in the Trust Fund Office no later than the 20th day of the month immediately before the month being covered. If you are receiving a monthly benefit from the Local 831 Pension Plan, then you must pay your required premium contribution via a deduction from your Local 831 Pension Plan monthly benefit. Otherwise, without this mandatory deduction to pay your monthly premium for Retiree COBRA, you will not be eligible to enroll and/or continue to receive Retiree COBRA coverage.

Please contact the Trust Fund Office for Local 831 Pension Plan benefit assignment forms so you may authorize your Retiree COBRA premiums to be automatically deducted from your Local 831 Pension Plan monthly benefit and avoid termination of your Retiree COBRA coverage.

Selection of Coverage

You will automatically be enrolled in the Level of Coverage and Plan option that last covered you as an Employee. However, you may choose to elect a lower level of coverage at the time of your initial enrollment or at any time in the future. You are only allowed to increase your level of coverage or switch between the Kaiser and Indemnity Health Plan options one time during the twelve (12) month period after you have elected retiree health coverage.

Reminder

The Board of Trustees has and retains the right at any time to amend, change or eliminate any benefit under this Plan or this Plan itself. Such decision shall be solely in the discretion of the trustees and may be without notice to the Participants. Such termination may apply to pending claims, claims in process and/or claims adjudicated.

SECTION 16

THIRD PARTY LIABILITY/SUBROGATION

If you or your Eligible Dependent suffer an injury or illness through the act or omission of someone else, the Plan shall pay benefits related to such injury or illness to the extent benefits are payable under the terms of the Plan, provided that the benefits have not already been paid by the third party. By accepting benefits from this Plan related to such an injury or illness, you agree to hold any reimbursement or other recovery received by you (or your Eligible Dependent, legal representative or agent) in trust on behalf of the Plan to cover all benefits paid by the Plan with respect to such injury or illness and to reimburse the Plan promptly for the benefits paid. Benefits are paid by the Plan subject to the condition that you and your Eligible Dependent do not take any action that would prejudice the Plan's ability to recover benefits paid and that you will cooperate in doing what is reasonably necessary to assist the Plan in obtaining reimbursement.

The Plan must be reimbursed in full up to the total amount of all benefits paid by the Plan in connection with the injury or illness from any recovery you receive from a third party, even if the recovery is not specifically identified as a reimbursement of medical expenses. All recoveries from a third party (whether by lawsuit, settlement, insurance or otherwise) must be used to reimburse the Plan for benefits paid. The Plan has the right of first reimbursement out of any recovery obtained, even if you are not fully compensated ("made whole") for your loss, and the Plan's claim has first priority over all other claims and rights. In addition, the Plan's claim is not subject to reduction for attorney's fees or costs under the "common fund" doctrine or otherwise. Any reduction of the Plan's claim is subject to prior written approval by the Trustees of the Plan in their sole discretion.

You are required to notify the Plan promptly (within 30 days) of any third party claim you may have for an injury or illness for which the Plan has paid or may pay benefits and any demand made or suit filed against any third party. You are required to notify the Plan promptly (within 30 days) of any third party recovery, whether in or out of court, that you or your Eligible Dependent obtain. If you choose not to pursue the liability of a third party, the Plan will be subrogated to your right of recovery and may pursue your claims against the third party. You agree to cooperate with the Plan with respect to any attempt to recover Plan benefits paid to you or your Eligible Dependent related to an injury or illness caused by the act or omission of a third party. You must sign a subrogation agreement and provide the Plan with any other relevant information about the claim if we ask you to do so. However, a subrogation agreement is not necessary to enforce the Plan's rights. You must forward any recovery to the Plan within 10 days of receipt or notify the Plan of why you are unable to do so. The Plan shall have a lien on any recovery until you reimburse the Plan for the amount of its claim. The Plan may offset its subrogation claim against any other Plan benefits otherwise due or payable to you and your Eligible Dependents without regard to on whose behalf the subrogated benefits were paid.

SECTION 17

CHANGES TO MEDICAL BENEFITS PURSUANT TO THE NO SURPRISES ACT

Background

The No Surprises Act ("NSA") was signed into law in December 2020 and protects patients from "balance billing" for non-PPO Emergency Services at certain independent freestanding emergency departments, non-PPO air ambulance services, and certain Non-Emergency Services performed by a non-PPO provider at a PPO facility (collectively "No Surprise Services"). You are still encouraged to use PPO providers and facilities whenever possible.

Covered employees and dependents receiving No Surprises Services will only be responsible for paying their PPO cost-sharing and cannot be balance billed by the provider or facility except in the limited situations where the notice and consent exception is applicable, as described below.

NSA Requirements

Emergency Services

The NSA requires Emergency Services to be covered as follows:

1. Without the need for any prior authorization determination, even if the services are provided on a non-PPO basis;

2. Without regard to whether the health care provider furnishing the Emergency Services is a PPO provider or a PPO emergency facility, as applicable, with respect to the services;

3. Without imposing any administrative requirement or limitation on non-PPO Emergency Services that is more restrictive than the requirements or limitations that apply to Emergency Services received from PPO providers and PPO emergency facilities;

4. Without imposing cost-sharing requirements on non-PPO Emergency Services that are greater than the requirements that would apply if the services were provided by a PPO provider or PPO emergency facility;

5. By calculating the cost-sharing requirement for non-PPO Emergency Services as if the total amount that would have been charged for the services were equal to the Recognized Amount for the services; and

6. By counting cost-sharing payments you make with respect to non-PPO Emergency Services toward your deductible and out-of-pocket maximum in the same manner as those received from a PPO provider.

Non-Emergency Services Performed by a Non-PPO Provider at a PPO Facility

The NSA requires Non-Emergency Services performed by a non-PPO provider at a PPO Health Care Facility to be covered as follows:

1. With a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the items or services had been furnished by a PPO provider;

2. By calculating the cost-sharing requirements as if the total amount that would have been charged for the items and services by such PPO provider were equal to the Recognized Amount for the items and services; and

3. By counting any cost-sharing payments made toward any deductible and out-of-pocket maximums applied under the Plan in the same manner as if such cost-sharing payments were made with respect to items and services furnished by a PPO provider.

Notice and Consent Exception: Non-emergency items or services performed by a non-PPO Provider at a PPO facility will be covered based on the non-PPO cost-sharing if:

1. At least 72 hours before the day of the appointment (or 3 hours in advance of services rendered in the case of a same-day appointment), you are provided with a written notice, as required by federal law, that the provider is a PPO provider with respect to the Plan, the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and

2. You give informed consent to continued treatment by the non-PPO provider, acknowledging that you understand that continued treatment by the non-PPO provider may result in greater cost to you.

The notice and consent exception does not apply to Ancillary Services and items or services furnished as a result of unforeseen, urgent medical needs that arise at the time an item or service is furnished, regardless of whether the non-PPO provider satisfied the notice and consent criteria.

Non-PPO Air Ambulance Services

If you receive air ambulance services that are otherwise covered by the Plan from a non-PPO provider, those services will be covered by the Plan as follows:

1. Air ambulance services received from a non-PPO provider will be covered with a cost-sharing requirement that is no greater than the cost-sharing requirement that would apply if the services had been furnished by a PPO provider.

2. In general, you cannot be balance billed for these items or services. Your cost-sharing will be calculated as if the total amount that would have been charged for the services by a PPO provider of air ambulance services were equal to the lesser of the Qualifying Payment Amount or the billed amount for the services.

3. Any cost-sharing payments you make with respect to covered air ambulance services will count toward your PPO deductible and PPO out-of-pocket maximum in the same manner as those received from a PPO provider.

Continuity of Coverage

If you are a Continuing Care Patient, and the Plan terminates its PPO contract with a PPO provider or facility, or your benefits are terminated because of a change in terms of the providers' and/or facilities' participation in the network:

1. You will be notified in a timely manner of the contract termination and of your and of your right to elect continued transitional care from the provider or facility; and

2. You will be allowed up to ninety (90) days of continued coverage a PPO cost-sharing to allow for a transition of care to a PPO provider.

Complaint Process

If you believe you have been wrongly billed, or otherwise have a complaint under the NSA, you may contact the federal government's NSA Helpdesk at 1-800-985-3059 or the Employee Benefits Security Administration ("EBSA") toll free number at 1-866-444-3272.

External Review Process of Certain Coverage Determinations

If your initial claim for benefits related to a No Surprises Service has been denied (i.e., an adverse benefit determination), and you are dissatisfied with the outcome of the Plan's internal claims and appeals process, you may be eligible for external review of the determination. Note that not all adverse benefit determinations are eligible for external review. Please contact the Trust Fund Office for more information.

SECTION 18

DEFINITIONS

1. "Accidental Injury" means a physical harm or disability, which is the result of a specific unexpected incident caused by an outside force. The physical harm or disability must have occurred at an identifiable time and place. Accidental injury does not include illness or infection, except infection of a cut or wound.

2. "Ancillary Services" means, with respect to a PPO Health Care Facility, the following:

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

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

    c. Diagnostic services, including radiology and laboratory services; and

    d. Items and services provided by a non-PPO provider if there is no PPO provider who can furnish such item or service at such facility.

3. "Confined" means that a Covered Person is an inpatient because of an injury or Sickness in any of the following facilities:

    a. a Hospital;

    b. a Skilled Nursing Facility;

    c. a Rehabilitation Facility;

    d. a Mental Disorder Facility; or

    e. a Substance Abuse Facility.

4. "Continuing Care Patient" means an individual who is: (1) receiving a course of treatment for a "Serious and Complex Condition;" (2) scheduled to undergo non-elective surgery (including any post-operative care); (3) pregnant and undergoing a course of treatment for the pregnancy; (4) determined to be terminally ill and receiving treatment for the illness; or (5) is undergoing a course of institutional or inpatient care from the provider or facility.

5. "Covered Person" means an Employee or a Dependent.

6. "Custodial" care means care made up of services or supplies that:

    a. are furnished mainly to train or assist in personal hygiene or other activities of daily living, rather than to provide therapeutic Treatment;

b. can safely and adequately be provided by persons who do not have the training and/or technical skills of a Physician;

c. are requested by or for the convenience of the patient or the patient's family; or

d. enable family members to work outside the home.

Activities of daily living include such things as:

a. bathing or dressing;

b. assistance with mobility; or

c. feeding or taking oral medicines.

Such care is Custodial regardless of

a. who recommends, provides, or directs care;

b. where the care is provided; or

c. whether or not the patient can be or is being trained for self-care.

7. "Dependent" includes only an Employee's:

a. legal spouse, (including same sex spouse) if not legally separated or

b. registered domestic partner*; and

c. children, including a legally adopted child or a child placed in your care in anticipation of adoption where the adoption is being actively pursued, foster child, a stepchild who resides in the Employee's household, and a child who is the subject of a Qualified Medical Child Support Order:

(1) who is less than age 26; or

(2) who is otherwise eligible, but reaches age 26 while covered by this Plan and is at that time incapacitated and for whom this Plan has received proof of incapacity:

(i) within 31 days after reaching the age limit; and

(ii) annually thereafter.

* Under California law, in order for opposite sex domestic partners to become registered domestic partners, one of the partners must be over the age of 62.

An incapacitated child is one:

(1) who is dependent on the Employee for support and maintenance;

(2) who has a developmental disability or physical handicap; and

(3) is diagnosed by a Physician as having a permanent or long term disability condition.

Developmental disability means substantial handicap which results from mental retardation, cerebral palsy, epilepsy, or other neurological disorder.

A Dependent does not include any person:

a. who is eligible for coverage as an Employee under this Plan, other than your spouse.

b. who is on active duty in the armed forces.

8. "Durable Medical Equipment" includes the "basic" models of:

a. mechanical respirators;

b. oxygen;

c. Hospital beds;

d. wheel chairs; and

e. similar medical equipment designed mainly for use in a Hospital for therapeutic purposes.

Durable Medical Equipment does not include such things as, without limitation, recreation equipment, air conditioners, spas, and exercise equipment even if prescribed by a Physician, nor does Durable Medical Equipment include modifications or maintenance or replacement of vehicles, residences, or other structures.

9. "Emergency" means there is a sudden, acute, and unexpected medical condition which, if not immediately diagnosed and treated, could lead to additional substantial disability or death.

10. "Emergency Medical Condition" means a medical condition, including mental health condition or substance use disorder, manifested by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in:

a. Serious impairment to bodily functions; or

b. Serious dysfunction of any bodily organ or part; or

c. With respect to a pregnant woman, placing the health of the woman or her unborn child in serious jeopardy.

11. "Emergency Services" means the following:

a. An appropriate medical screening examination that is within the capability of the emergency department of a hospital or of an independent freestanding emergency department (some urgent care facilities, but not all, qualify), as applicable, including Ancillary Services routinely available to the emergency department to evaluate such emergency medical condition; and

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

c. Emergency Services furnished by a non-PPO provider or non-PPO emergency facility (regardless of the department of the hospital in which such items or services are furnished also includes post stabilization services (services after the patient is stabilized)) and as part of outpatient observation or an inpatient or outpatient stay related to the emergency medical condition, until:

(1) The provider or facility determines that you are able to travel using nonmedical transportation or nonemergency medical transportation; and

(2) You are supplied with a written notice, as required by federal law, that the provider is a non-PPO provider with respect to the Plan, of the estimated charges for your treatment and any advance limitations that the Plan may put on your treatment, of the names of any PPO providers at the facility who are able to treat you, and that you may elect to be referred to one of the PPO providers listed; and

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

12. "Employee" means an eligible person who is employed by an employer, union, or Trust maintaining this Plan.

13. "Experimental" means any medical procedure, equipment, treatment or course of treatment, of drugs or medicines that are:

a. limited to research;

b. not proven in an objective manner to have substantial therapeutic value or benefit;

c. restricted to use by medical facilities capable of carrying out scientific studies;

d. of questionable medical effectiveness; or

e. would be considered inappropriate medical treatment.

To determine whether a procedure is experimental, the Trustees will consider, among other things, commissioned studies, opinions and references to or by the American Medical Association, the federal Food and Drug Administration, the Department of Health and Human Services, the National Institutes of Health, the Council of Medical Specialty Societies and any other association or program or agency that has the authority to review or regulate medical testing or treatment.

14. "Health Care Facility" (for Non-Emergency Services) means each of following:

a. A hospital (as defined in section 1861(e) of the Social Security Act);

b. A hospital outpatient department;

c. A critical access hospital (as defined in section 1861(mm)(1) of the Social Security Act); and

d. An ambulatory surgical center described in section 1833(i)(1)(A) of the Social Security Act.

15. "Hospice" is a special kind of care designed to treat people with terminal illnesses, whose doctors give them less than six months to live. It is provided by a certified hospice agency. It includes palliative care to make the patient more comfortable and is delivered in lieu of other medical care designed to cure the terminal illness. Hospice care is designed to provide supportive, end-of-life care and is delivered by a specialized network of providers.

16. "Hospital" is a facility which provides diagnosis, treatment, and care of persons who need acute inpatient. Hospital care under the supervision of medical or osteopathic doctors. It must be licensed as a general acute care Hospital according to state and local laws. It must also be registered as a general hospital by the American Hospital Association and accredited by the Joint Commission on Accreditation of Hospitals.

17. "Incurred" means the date the Covered Person receives or is furnished the confinement, service, or supply for which the charge is made.

18. "Maintenance" care is care made up of services that are furnished mainly to:

a. Maintain, rather than improve, a level of physical, or mental function; or

b. Provide a surrounding free from exposures that can worsen the person's physical or mental condition.

19. "Medically Necessary" means:

a. there is a Sickness or injury which requires drugs, therapies, or treatment; and

b. the drugs, therapies or other treatments that are required are appropriate care for the Sickness or the injury, and

(1) are given in accordance with generally accepted principles of medical practice in the United States at the time furnished;

(2) are approved for reimbursement by the Health Care Financing Administration; and

(3) are not experimental, educational or investigational; and

(4) are not furnished in connection with medical or other research.

c. Diagnostic X-rays and lab tests are Medically Necessary when:

(1) performed due to definite symptoms of Sickness or injury; or

(2) they reveal the need for Treatment.

20. "Medicare" means Title XVIII (Health Insurance for the Aged) of the U.S. Social Security Act, as amended.

21. a. "Mental Disorder Facility" is a facility licensed to provide inpatient or outpatient treatment services for individuals diagnosed with mental disorders, as defined in the edition of the Diagnostic and Statistical Manual of Mental Disorders that is current as of the date of service.

b. In the sole and exclusive discretion of the trustees, a Residential Treatment Center may be deemed to be a Mental Disorder Facility if all the following requirements are met in an individual case:

1. a Residential Treatment Center is the only medically advisable alternative to an inpatient hospitalization; and

2. a Residential Treatment Center is both safe and appropriate for the patient and is more cost effective than a Mental Disorder Facility; and

3. the Residential Treatment Center is in-network; and

4. No more than 15 days are allowed for any participant or beneficiary for inpatient treatment at a Residential Treatment Center in any one calendar year.

22. "Myofascial Pain Dysfunction" (M.P.D.) is a disorder involving muscles surrounding and adjacent to the temporomandibular joint (T.M.J.) area which is characterized by:

    a. preauricular, temporal, occipital and/or jaw pain;

    b. spasm and or tenderness of the masticatory muscles;

    c. limited jaw movement.

23. "No Surprises Services" means the following, to the extent covered under the Plan:

    a. non-PPO Emergency Services;

    b. non-PPO air ambulance services;

    c. Non-emergency Ancillary Services for anesthesiology, pathology, radiology and diagnostics, when performed by a non-PPO provider at a PPO facility; and

    d. Other non-PPO Non-Emergency Services performed by a non-PPO provider at a PPO Health Care Facility with respect to which the provider does not comply with federal notice and consent requirements.

24. "Participant" means an Employee or a Dependent.

25. "Physician" means one of the following licensed providers, but only when the provider is rendering a service within the scope of the license:

    a. doctor of medicine (M.D.);

    b. doctor of osteopathy (D.O.);

    c. dentist (D.D.S.);

    d. optometrist (O.D.);

    e. podiatrist (D.P.M.);

    f. psychologist (Ph.D);

    g. chiropractor (D.C.);

    h. Marriage Family Child Counselor (M.F.C.C.)

    i. Licensed Clinical Social Worker (L.C.S.W.).

    j. Physician's Assistant (P.A.)

    k. Midwife (C.N.M.)

This definition does not include someone who is related to a covered person by blood, marriage or adoption or is normally a member of a covered person's household.

26. "Qualifying Payment Amount" or "QPA" means generally the median contracted rates of the plan or issuer for the item or service in the geographic region, calculated in accordance with 29 CFR 716-6(c).

27. "Recognized Amount" means one of the following:

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

    b. If there is no applicable All-Payer Model Agreement, an amount determined by a specified state law; or

    c. If there is no applicable All-Payer Model Agreement or state law, the lesser of the amount billed by the Provider or facility or the QPA.

    For air ambulance services furnished by non-PPO providers, the Recognized Amount is the lesser of the amount billed by the provider or facility or the QPA.

28. "Rehabilitation Facility" is a non-residential facility that is established and operated exclusively for the purpose of providing comprehensive diagnostic, therapeutic, and restorative services for the rehabilitation of injured, disabled, or sick persons, at a single fixed location, by or under the supervision of a physician.

29. "Rehabilitative Care" represents the phase of care following acute inpatient treatment of an illness or injury. It is designed to restore functional capacity that previously existed and was lost due to the illness or injury. For example, following the inpatient treatment of a stroke or head injury, a rehabilitative program could be developed to include speech and physical therapies.

30. "Schedule" means the Schedule of Coverage.

31. "Serious and Complex Condition" means one of the following:

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

    b. In the case of a chronic illness or condition, a condition that is the following:

        (1) Life-threatening, degenerative, potentially disabling, or congenital; and

        (2) Requires specialized medical care over a prolonged period of time.

32. "Sickness" includes pregnancy.

33. “Skilled Nursing Facility” means a lawfully operated institution that:

a. provides room and board;

b. provides daily, 24-hour skilled nursing service:

(1) through one or more professional nurses;

(2) primarily for persons convalescing from bodily Sickness or injury;

c. is supervised by a Physician or has available the services of a Physician by an established agreement; and

d. maintains adequate medical records.

It does not include:

a. a rest home;

b. a nursing home; or

c. a place for Custodial or Maintenance care.

34. “Substance Use Disorder” refers to those conditions which are listed in the International Classification of Diseases as diagnostic codes 303 through 305 (but excluding 305.1), which include alcoholism and drug dependence.

35. “Substance Use Disorder Facility” is a facility licensed to provide inpatient or outpatient treatment services for individuals diagnosed with Substance Abuse Disorder.

36. “Temporomandibular Joint (T.M.J.) Dysfunction” is a disorder of the temporomandibular joint (the joint which connects the mandible or jawbone to the temporal bone) which is generally characterized by:

a. pain or muscle spasms in one or more of the following areas; face, jaw, neck, head, ears, throat, or shoulders;

b. popping or clicking of the jaw;

c. limited jaw movement or locking;

d. malocclusion, overbite or underbite; or

e. mastication (chewing) difficulties.

37. “Totally Disabled” refers to:

a. an Employee who cannot perform the usual and customary duties of the Employee’s occupation; or

b. a Dependent who cannot carry on any substantial part of the Dependent's normal activities.

38. "Treatment" means the consultations, tests, procedures, medications, and interventions that are:

a. customarily applied in the care of persons with similar complaints and findings by similarly trained practitioners; and

b. generally accepted as the effective elements of care.

39. "Usual, Customary and Reasonable" or "UCR" means a charge that does not exceed the general level of charges made by others of similar standing as determined by this Plan:

a. in the locality where the charge is Incurred;

b. when furnishing similar services or supplies;

(1) to persons of the same sex and similar age

(2) for a similar Sickness or injury; and

c. for services or supplies generally considered by medical professionals to provide substantially the same benefits at significantly lower cost.

Locality means the same county or a greater area when necessary to obtain a true cross-section.

40. Other Definitions:

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SECTION 19

CLAIMS AND APPEALS PROCEDURES

CLAIMS PROCEDURES

All claims for benefits under this Plan should be submitted by your provider to your local Blue Cross and/or Blue Shield Plan. To ensure prompt claims processing, include the 3-digit alpha prefix that precedes the patient's identification number listed on the front of the medical card.

California service providers send all medical claims to:

Anthem Blue Cross
P.O. Box 60007
Los Angeles, CA 90060

For eligibility, benefits and inquiries contact:

Southern California Local Union 831 - Employer Health Fund
P.O. Box 3118
Covina, CA 91722-9118

Charges for hospital confinement, surgical treatment, doctor visits, and dental or vision care must be itemized.

Time Frames for Submitting and Deciding Claims

All claims must be submitted within **12 months** of the date of service. Any claim that is not submitted within 12 months of the date of service will be denied as untimely.

A claim for benefits is a request for payment of benefits made in accordance with the Plan's claims procedures. A simple inquiry about Plan provisions or eligibility will not be treated as a claim, nor will a request for prior approval of a benefit that does not require prior approval be treated as a claim.

Kaiser enrollees should follow only the procedures set forth in the Kaiser Plan booklet.

If you are enrolled in Kaiser and have a complaint about the quality of medical services provided by Kaiser, you may also report such matter directly to the Board of Trustees, for information purposes only.

Please keep the following definitions in mind when reviewing these procedures:

- A **pre-service claim** is a claim for a benefit that requires you to obtain approval in advance of obtaining the care. For example, claims for inpatient mental health treatment require pre-approval (also called pre-certification).

- A **post-service claim** is a claim for a benefit that does not require pre-approval or

pre-certification before you receive the benefit. For example, most doctor visits do not require you to obtain pre-certification before you receive the service.

- An **urgent care claim** is any pre-service claim for medical care or treatment with respect to which the application of the time periods for making pre-service determinations (1) could seriously jeopardize your life or health or your ability to regain maximum function, or (2) in the opinion of a Physician with knowledge of your medical condition, would subject you to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. Whether a pre-service claim is urgent will be determined applying the judgment of a prudent layperson who possesses an average knowledge of health and medicine. Alternatively, any pre-service claim that a Physician with knowledge of your medical condition determines is urgent shall be treated as an urgent care claim.

- A **concurrent care claim** is a claim that is reconsidered after an initial approval is made and subsequently reduced, terminated or extended. An example would be an inpatient mental health admission that is originally pre-certified for ten days but is then reviewed at five days to determine if the full ten-day confinement is appropriate. In this situation, a decision to reduce, terminate or extend treatment is made concurrently with the provision of treatment.]

Post-Service Claims

Ordinarily, you will be notified of the decision on your claim within **30 days** from receipt of your claim. This period may be extended once, for up to **15 days** if necessary due to matters beyond the control of this Plan provided that, prior to the expiration of the initial 30-day period, you are notified of the reasons for the extension and the date by which a decision will be made. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you will have **45 days** from your receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period you are given to supply additional information, the 30-day period for deciding the claim will be suspended from the date of the extension notice until the earlier of (i) 45 days, or (ii) until the date you respond to the request. The Plan then has **15 days** to decide your claim and notify you of the determination.

Pre-Service Claims

If you provide all the required information when you call Anthem for pre-authorization you will be notified of the decision on your pre-authorization request within **15 days** of your call unless additional time is needed due to matters beyond the control of Anthem or the Plan. Under those circumstances, the time to decide your claim may be extended by up to **15 days**. Prior to the expiration of the initial 15-day period, you will be notified of the circumstances necessitating the extension and the date on which a decision will be made. If an extension is needed because additional information is needed from you, the extension notice will specify the information needed. In that case, you and/or your provider will have **45 days** from receipt of the notification to supply the additional information. If the information is not provided within that time, your claim will be denied. During the 45-day period which you are provided to supply additional

information, the 15-day period for deciding the claim will be suspended from the date of the extension notice until the earlier of (i) either 45 days, or (ii) the date you respond to the request. Your claim will be decided, and you will be notified of the determination within **15 days**.

Concurrent Care Claims

Your request that we reconsider termination or reduction of a previously approved benefit (other than by plan amendment or termination) that constitutes an urgent care claim will be made within 24 hours of receipt of your request for reconsideration or early enough to permit an appeal to be decided before the benefit is reduced or terminated.

Urgent Care Claims

The Plan will respond to you (and your Physician) with a determination of your urgent care claim by telephone as soon as possible taking into account the medical exigencies, but not later than **72 hours** after receipt of the claim. The determination will be confirmed in writing.

If an urgent care claim is received without sufficient information to determine whether or to what extent benefits are covered or payable, you (and your Physician) will be notified as soon as possible, but not later than **24 hours** after receipt of the claim, of the specific information necessary to complete the claim. You and/or your Physician must provide the specified information within **48 hours**. If the information is not provided within that time, your claim will be denied. Notice of the decision will be provided no later than **48 hours** after receipt of the specified information.

Notice of Decision

You will be provided with written notice of a denial of a claim. This notice will include:

- The specific reason(s) for the determination.
- The specific Plan provision(s) on which the determination is based.
- A description of any additional material or information necessary to perfect the claim, and an explanation of why the material or information is necessary.
- A description of the appeal procedures and applicable time limits.
- A statement of your right to bring a lawsuit under ERISA following an adverse benefit determination on review.
- If an internal rule, guideline or protocol was relied upon in deciding your claim, you will receive either a copy of the rule or a statement that it is available upon request at no charge.
- If the determination was based on the absence of medical necessity, or because the treatment was Experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon

request at no charge.

APPEALS PROCEDURE

If your claim is denied in whole or in part, you may appeal to the Board of Trustees (the "Trustees") in writing within **180 days** after you receive the denial and shall state why you believe the denial is incorrect. Decisions on appeals ordinarily will be made at the next regularly scheduled Trustees' meeting following receipt of your appeal. However, if your appeal is received within 30 days of the next regularly scheduled meeting, your appeal will be considered at the second regularly scheduled meeting following receipt of your appeal. In special circumstances, a delay until the third regularly scheduled meeting following receipt of your appeal may be necessary. You will be advised in writing in advance if this extension will be necessary. You will be notified of the Trustees' decision as soon as possible, but no later than 5 days after the decision has been reached.

APPEAL RIGHTS

Right to Review Documents and to Obtain Other Information

You have the right to review documents relevant to your claim. A document, record or other information is relevant if it was relied upon in making the decision; it was submitted, considered or generated (regardless of whether it was relied upon); it demonstrates compliance with this Plan's administrative processes for ensuring consistent decision making or it constitutes a statement of this Plan's policy regarding the denied treatment or service.

Upon request, you will be provided with the identification of medical experts, if any, that advised the Plan concerning your claim, without regard to whether the advice was relied upon in deciding your claim.

Right to Independent Review

A different person will consider your appeal than the one who originally denied the claim. The reviewer will not give deference to the initial denial. The decision will be made on the basis of the record, including such additional documents and comments that you submit.

Cases Involving a Medical Judgment

If your claim was denied on the basis of a medical judgment (such as a determination that the treatment or service was not Medically Necessary, or was investigational or Experimental), a health care professional who has appropriate training and experience in a relevant field of medicine will be consulted. The health care professional will not have been consulted in connection with the initial claim that is the subject of the appeal and will not be the subordinate of any individual who was so consulted.

Notice of the Determination of your Appeal

Appeal decisions will be in writing and will include the following information:

- The specific reason(s) for the determination.

- Reference to the specific Plan provision(s) on which the determination is based.

- A statement that you are entitled to receive reasonable access to and copies of all documents relevant to your claim, upon request and free of charge.

- A statement of your right to bring a lawsuit under ERISA Section 502(a) following an adverse benefit determination on review.

- If an internal rule, guideline or protocol was relied upon by the Plan, you will receive either a copy of the rule or a statement that it is available upon request at no charge.

- If the determination was based on medical necessity, or because the treatment was Experimental or investigational, or other similar exclusion, you will receive an explanation of the scientific or clinical judgment for the determination applying the terms of the Plan to your claim, or a statement that it is available upon request at no charge.

The Trustees shall, subject to the requirements of applicable law, be the sole judges of the standard of proof required in any claim and the application and interpretation of this Plan and any of the plan documents. Without limiting the generality of the foregoing, the Trustees shall have the sole and absolute discretionary authority to:

- Take all actions and make all decision with respect to the eligibility for and the amount of benefits payable under the Plan;
- Formulate, interpret and apply rules, regulations and policies necessary to administer the Plan in accordance with its terms;
- Decide questions, including legal and factual questions, relating to the payment of benefits under the Plan;
- Resolve and/or clarify any ambiguities, inconsistencies and omissions arising under the summary plan description or other Plan documents;
- Process and approve or deny benefit claims and rule on any benefit exclusions; and
- Decide all matters arising in connection with the operation or administration of the Plan.

The decision of the Board of Trustees or its designated committee will be final and binding on all parties and shall be given deference in all courts of law to the greatest extent allowed by applicable law.

SECTION 20 IMPORTANT NOTICES

If you have any questions about the notices below, please call the Trust Fund Office at (877) 572-7005 or (626) 279-3080.

Grandfathered Status Notice

The Southern California Local Union 831 — Employer Health Fund believes this plan is a "grandfathered health plan" under the Patient Protection and Affordable Care Act (the Affordable Care Act). As permitted by the Affordable Care Act, a grandfathered health plan can preserve certain basic health coverage that was already in effect when that law was enacted. Being a grandfathered health plan means that your plan may not include certain consumer protections of the Affordable Care Act that apply to other plans, for example, the requirement for the provision of preventive health services without any cost sharing. However, grandfathered health plans must comply with certain other consumer protections in the Affordable Care Act, for example, the elimination of lifetime limits on benefits, and the external review requirements under the No Surprises Act.

Questions regarding which protections apply and which protections do not apply to a grandfathered health plan and what might cause a plan to change from grandfathered health plan status can be directed to the plan administrator at P.O. Box 3118, Covina, California 91722-9118; (877) 572-7005. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform. This website has a table summarizing which protections do and do not apply to grandfathered health plans.

Women's Health and Cancer Rights Act (WHCRA)

Your health plan is required by the Women's Health and Cancer Rights Act of 1998 to provide benefits for mastectomy-related services, including the following services:

- Reconstruction of the breast on which the mastectomy has been performed.
- Surgery and reconstruction of the other breast to produce a symmetrical appearance.
- Prostheses and physical complications for all stages of a mastectomy, including lymphedemas (swelling associated with the removal of lymph nodes).

Your plan will provide coverage in consultation with the attending physician and patient.

Coverage for breast reconstruction and related services will be subject to deductible, copayments and coinsurance amounts that are consistent with those that apply to other benefits under the Plan. If you have any questions about the Women's Health and - Cancer Rights Act, please call the Trust Fund Office at (877) 572-7005 or (626) 279-3080.

Newborn's and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than:

- 48 hours following a normal vaginal delivery, or
- 96 hours following a cesarean section.

However, federal law generally does not prohibit the mother's or newborn's attending provider (physician), after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable).

In any case, plans and issuers may not, under federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a hospital stay not in excess of 48 hours (or 96 hours). However, the plan may still require precertification or preauthorization from the plan or the issuer for prescribing a length of stay in excess of 48 hours or 96 hours.

Qualified Medical Child Support Order (QMCSO)

This Plan honors qualified medical child support orders (QMCSOs). This means that if a QMCSO issued in connection with a divorce or legal separation proceeding requires you to provide medical coverage to a child who is not in your custody, you may do so under this Plan. To be qualified, a medical child support order must include the following information:

- Name and last known address of each child to be covered under this Plan.
- Name and last known address of the parent who has been granted legal custody.
- Type of coverage to be provided to each child and period of time coverage will be provided.

Send QMCSOs to the Trust Fund Office, which is your Plan administrator. Upon receipt, the Trust Fund Office will notify you and give you, without charge, a copy of the procedures for determining if the order is qualified. If the order 'is qualified, you may cover your child/children under this Plan.

Leaves of Absence for Military Service

If you are on active military duty for 30 days or less, you will continue to receive benefits under this Plan during that period in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 ("USERRA"). If you are on active military duty for more than 30 days, your coverage under the Plan ends, but USERRA permits you to continue healthcare coverage for you and your Dependents at your own expense for up to 24 months while you are on active military duty. This continuation right operates in the same way as COBRA coverage, which is described in SECTION 14. In addition, your Dependent(s) may be eligible for health care

coverage under the federal program known as TRICARE (which includes the former "CHAMPUS" program).

Except as otherwise provided for by law or as set forth below, even if you do not elect to continue coverage during your military service of more than 30 days, your coverage will be reinstated when you return to work provided that you notify the Employer of your intent to return within one of the following time frames:

- 90 days from the date of the completion of the period of military service, if the period of service was more than 180 days; or

- 14 days from the date of the completion of the period of military service, if the period of service was at least 31 days but less than 181 days. If giving such notice within this period is impossible or unreasonable through no fault of your own, you must provide notice to your Employer on the first day possible.

If your period of service was less than 31 days, you must report to the Employer no later than the beginning of the first full regularly scheduled work period on the first full day following completion of service plus eight (8) hours after a period allowing for your safe transportation home. If reporting within this period is impossible or unreasonable through no fault of your own, you must report as soon as possible after eight (8) hours after a period allowing for your safe transportation home.

Failure to report for work or give notice of your return to work in accordance with the foregoing paragraphs shall not automatically deprive you of your rights to benefits. However, to avoid jeopardizing your right to benefits you should comply with the deadlines set forth above.

If you are Hospitalized or convalescing from an illness or injury incurred or aggravated during active duty, these time limits may be extended up to two (2) years while you recover.

No waiting period or exclusion will be imposed in connection with your reinstatement (unless the waiting period or exclusion would have been imposed if you remained covered during your military service) except in the case of any illness or injury determined by the Secretary of Veteran Affairs to have been incurred or aggravated during performance of your military service.

Separation from military service that is dishonorable or based on bad conduct, on other than honorable conditions, or as otherwise set forth in USERRA (29 U.S.C. § 4304) will disqualify you from any rights pertaining to your entitlement to medical benefits under USERRA as set forth above.

Under USERRA, an active employee is required to notify the employer (in writing or orally) that he or she is leaving for military service unless circumstances or military necessity make notification impossible or unreasonable. Your Employer is required to notify this Plan within 30 days after you are reemployed following military service. You should also promptly notify the Fund Office of your return to work.

Contact your Employer if you have questions regarding military service leave. Contact the Trust Fund Office if you have questions regarding coverage during such leave.

HIPAA Notice of Privacy Practices

NOTICE OF PRIVACY PRACTICES FOR PROTECTED HEALTH INFORMATION

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice is required by the Standards for the Privacy of Individually Identifiable Health Information ("Privacy Rules"), Federal rules issued by the U.S. Department of Health and Human Services pursuant to the Health Insurance Portability and Accountability Act of 1996 (HIPAA). It describes how the Plan can use and disclose your Protected Health Information.

Protected Health Information ("PHI") is information that is created, received, transmitted or stored by the Plan which relates to your past, present, or future physical or mental health, health care, or payment for health care, and either identifies you or provides a reasonable basis for identifying you. In general, the Plan may not use or disclose your PHI unless you consent to or authorize the use or disclosure, or if the Privacy Rules specifically allow the use or disclosure.

The Plan is legally required to maintain the privacy of your PHI. The primary purpose of this notice is to describe the legally permitted uses and disclosures of PHI, even though some may not apply to this Plan in practice. This notice also describes your right to access and control your PHI.

The Plan is required to abide by the terms of this Notice. The Trustees reserve the right to change the terms of this or any subsequent Notice at any time. If any changes are made, the revised Notice will be effective for all PHI that the Plan maintains at that time. Within 60 days of any material revision to the Plan's privacy practices, the Plan will distribute a new Notice. Additionally, you may contact the Plan directly at any time to obtain a copy of the most recent Notice.

Use or Disclosure of PHI

1. **The Plan may use or disclose your PHI for treatment, payment, or health care operations without your written authorization. However, most uses and disclosures of psychotherapy notes relating to you, uses and disclosures of your PHI for marketing purposes, and disclosures that constitute sales of your PHI require your authorization.**

    - "Payment" generally means the activities of a plan to collect premiums, to fulfill its coverage responsibilities, and to provide benefits under the plan, and to obtain or provide reimbursement for the provision of health care. Payment may include, but is not limited to, the following: (1) determining coverage and benefits under the plan, (2) paying for or obtaining reimbursement for health care, (3) adjudicating subrogation of health care claims or coordination of benefits, (4) billing and collection, (5) making claims for stop-loss insurance, (6) determining medical necessity and (7) performing utilization review activities. For example, the Plan will disclose the minimum necessary PHI to medical service providers for the purposes of payment.

- "Health Care Operations" are certain administrative, financial, legal, and quality improvement activities of a covered entity (such as the Plan) that are necessary to run its business and to support the core functions of treatment and payment. For example, the Plan may disclose the minimum necessary PHI to the Plan's attorney, auditor, actuary, and consultant(s) when these professionals perform services for the Plan that requires them to use PHI. Persons who perform services for the Plan are called "business associates." Federal law requires the Plan to have written contracts with its business associates before it shares PHI with them, and the Plan's disclosures of your PHI must be consistent with the Plan's contract with them. Other examples of business associates are the Plan's stop-loss insurance carrier, claims repricing services, utilization review companies, prescription benefit managers, PPOs, and HMOs.

- "Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider to another. The Plan is not typically involved in treatment activities.

2. **The Plan is permitted or required to use or disclose your PHI without your written authorization for the following purposes and in the following circumstances, as limited by law (note that these activities are not considered treatment, payment and health care operations):**

    - The Plan will use or disclose your PHI to the extent it is required by law to do so. Thus, the Plan may disclose your PHI under certain conditions in response to a subpoena, discovery request or other lawful process in which case reasonable efforts must be undertaken by the party seeking the PHI to notify you and give you an opportunity to object to this disclosure.

    - The Plan may disclose your PHI to a public health authority for certain public health activities, such as: (1) reporting of a disease or injury, or births and deaths, (2) conducting public health surveillance, investigations, or interventions; (3) reporting known or suspected child abuse or neglect; (4) ensuring the quality, safety or effectiveness of an FDA-regulated product or activity; (5) notifying a person who is at risk of contracting or spreading a disease; and (6) notifying an employer about a member of its workforce, for the purpose of workplace medical surveillance or the evaluation of work-related illness and injuries, but only to the extent the employer needs that information to comply with the Occupational Safety and Health Administration (OSHA), the Mine Safety and Health Administration (MSHA), or State law requirements having a similar purpose.

    - The Plan may disclose your PHI to the appropriate government authority if the Plan reasonably believes that you are a victim of abuse, neglect, or domestic violence.

- The Fund may disclose your PHI to a health oversight agency for oversight activities authorized by law, including (1) audits; (2) civil, administrative, or criminal investigations; (3) inspections; (4) licensure or disciplinary actions; (5) civil, administrative, or criminal proceedings or actions; and (6) other activities.

- The Plan may disclose your PHI in the course of any judicial or administrative proceeding in responses to an order by a court or administrative tribunal, or in response to a subpoena, discovery request, or other lawful process.

- The Plan may disclose your PHI for a law enforcement purpose to a law enforcement official. Such purposes include disclosures required by law, or in compliance with a court order or subpoena, grand jury subpoena, or administrative request.

- The Plan may disclose your PHI in response to a law enforcement official's request, for the purpose of identifying or locating a suspect, fugitive, material witness or missing person.

- The Plan may disclose your PHI if you are the victim of a crime and you agree to the disclosure or if the Plan is unable to obtain your consent because of incapacity or emergency, and law enforcement demonstrates a need for the disclosure and/or the Plan determines in its professional judgment that such disclosure is in your best interest.

- The Plan may disclose your PHI to a law enforcement official to inform them of your death if the Plan believes your death may have resulted from criminal conduct.

- The Plan may disclose PHI to a law enforcement official that it believes is evidence that a crime occurred on the premises of the Plan.

- The Plan may disclose your PHI to a coroner or medical examiner for identification purposes. The Plan may disclose your PHI to a funeral director to carry out their duties upon your death or prior to and in reasonable anticipation of your death.

- The Plan may disclose your PHI to organ procurement organizations for cadaveric organ, eye, or tissue donation purposes.

- The Plan may use or disclose your PHI for research purposes, if the Plan obtains one of the following: (1) documented institutional review board or privacy board approval; (2) representations from the researcher that the use or disclosure is being used solely for preparatory research purposes; (3) representations from the researcher that the use or disclosure is solely for research on the PHI of decedents; or (4) an agreement to exclude specific information identifying the individual.

- The Plan may use or disclose your PHI to avoid a serious threat to the health or safety of you or others.

- The Plan may disclose your PHI if you are in the Armed Forces and your PHI is needed by military command authorities. The Plan may also disclose your PHI for the conduct of national security and intelligence activities.

- The Plan may disclose your PHI to a correctional institution where you are being held.

- The Plan may disclose your PHI as authorized by and to the extent necessary to comply with laws relating to workers' compensation or other similar programs.

3. **The Plan may use or disclose your PHI to you, to your Personal Representative, to a third party (such as your spouse or a local union official) pursuant to an Authorization Form, and to the Board of Trustees of the Plan but only for the purposes and to the extent specified in the Plan:**

    - The Plan will provide you with access to your PHI. The Plan will first require you to complete and execute a "Request for Protected Health Information Form" and will provide you with access to PHI consistent with the Request Form, or as otherwise required by law. ***If you wish to make a request for a Request for Protected Health Information Form, please contact the Privacy Officer whose name and address are shown on the last page of this notice.***

    - The Plan may provide your Personal Representative or Attorney with access to your PHI in the same manner as it would provide you with access, but only upon receipt of documentation demonstrating that your Personal Representative or lawyer has authority under applicable law to act on your behalf. If the Plan has reasonable doubt about an individual's status as Personal Representative, the matter shall be referred to Fund Counsel.

    - Unless otherwise permitted by law, the Plan will not use or disclose your PHI to someone other than you unless you sign and execute an "Authorization Form." You can revoke an Authorization Form at any time by submitting a "Cancellation of Authorization Form" to the Plan. The Cancellation of Authorization Form revokes the Authorization Form on the date it is received by the Plan. ***If you wish to make a request for an Authorization Form and a Cancellation of Authorization Form, please contact the Privacy Officer whose name and address are shown on the last page of this notice.***

    - The Plan will disclose your PHI to the Plan's Board of Trustees only in accordance with the provisions of the Plan's Privacy Policy and the provisions of the Plan.

Individual Rights

You have certain important rights with respect to your PHI. You should contact the Plan's Privacy Officer, identified below, to exercise any of these rights. These rights include:

- You have a right to request that the Plan restrict use or disclosure of your PHI to carry out payment or health care operations. Although the Plan is not required to agree to a

requested restriction, it will notify you if the restriction is not accepted. You have a right to receive confidential communications about your PHI from the Plan by alternative means or at alternative locations, or you may designate certain parties to receive communications from the Plan on your behalf, if you submit a written request to the Plan in which you clearly state that the disclosure of all or part of that information could endanger you.

- You have a right to inspect and obtain a copy of your PHI that is maintained by the Plan in a "designated record set" if you submit a valid "Request for Protected Health Information Form" to the Plan. A "designated record set" consists of records or other information containing your PHI that is maintained, collected, used, or disseminated by or for the Plan in connection with: (1) enrollment, payment, claims adjudication, and case or medical management record systems maintained by or for the Plan, or (2) decisions that the Plan makes about you. If you request copies of your PHI, the Plan may charge a reasonable fee for copying, assembling costs and postage, if applicable, associated with your request. The requested information will be provided within 30 days. A single 30-day extension is allowed if the Plan is unable to comply with the deadline. If the Plan uses or maintains an electronic health records with respect to your PHI, you may request such PHI in an electronic format, and direct (in a signed written request) that such PHI be sent to another person or entity. If you request a copy, please indicate in which form you want to receive it (i.e., paper or electronic). The Plan may decide to deny access to your PHI if it is determined that the requested access is reasonably likely to endanger the life or physical safety of you or another individual or to case substantial harm to you or another individual, or if the records make reference to another person (other than a health care provider) and the requested access would cause substantial harm to the other person. Depending on the circumstances, that decision to deny access may be reviewable by a licensed health professional who was not involved in the initial denial of access and who has been designated by the Plan to act as a reviewing official.

- You have a right to amend your PHI that was created by the Plan and that is maintained by the Plan in a designated record set, if you submit a written request to the Plan in which you provide reasons for the amendment.

- You have a right to receive an accounting of disclosures of your PHI, with certain exceptions, if you submit a written request to the Plan. The Plan need not account for disclosures that were made more than six years before the date on which you submit your request, nor any disclosures that were made for treatment, payment or health care operations. ***This applies only to disclosures made on or after April 14, 2003.***

Duties of the Plan

The Plan has the following obligations:

- The Plan is required by law to maintain the privacy of PHI and to provide individuals with notice of its legal duties and privacy practices with respect to PHI. To obtain a

copy of the Plan's entire Privacy Policy, you should contact the Plan's Privacy Officer, identified below.

- The Plan is required to abide by the terms of the Notice that is currently in effect.

- The Plan will provide a paper copy of this Notice to you upon request.

- If your "unsecured" PHI is accessed, acquired, used or disclosed in a manner that is considered a "breach" as defined under HIPAA, or that is not permitted under the HIPAA privacy rules and that poses a significant risk of financial, reputational, or other harm to you, the Plan must take specified steps to notify you within 60 days of discovery of such breach. Unsecured PHI is PHI that is not rendered unusable or indecipherable to unauthorized persons through certain specified technologies and methodologies.

- The Plan will not use or disclose your PHI that is "genetic information" for "underwriting" purposes as defined by the Genetic Information Nondiscrimination Act of 2008.

Changes to Notice

- The Plan reserves the right to change the terms of this Notice and to make the new Notice provisions effective for all PHI it maintains, regardless of whether the PHI was created or received by the Plan prior to issuing the revised Notice.

- Whenever there is a material change to the Plan's uses and disclosures of PHI, individual rights, the duties of the Plan, or other privacy practices stated in this Notice, the Plan will promptly revise and distribute the new Notice **to participants and beneficiaries.**

Contacts and Complaints

If you believe your privacy rights have been violated, you may file a written complaint with the Plan's Privacy Officer at the following address:

Privacy & Security Officer
Pacific Southwest Administrators
1055 Park View Drive, Suite 111
Covina, CA 91724

Telephone: (626)-279-3080 (Local)
(877)-572-7005

You may also file a complaint with the U. S. Secretary of Health and Human Services in Washington, DC. The Plan will not intimidate, threaten, coerce, discriminate against, or take other retaliatory action against any person for filing a complaint.

For More Information About Privacy

If you want more information about the Plan's policies and procedures regarding privacy of PHI, contact the Plan's Privacy Officer at the address above.

SECTION 21 ERISA RIGHTS AND RESPONSIBILITIES

YOUR RIGHTS AND RESPONSIBILITIES UNDER THE EMPLOYEE RETIREMENT INCOME SECURITY ACT OF 1974 (ERISA)

As a Participant in the Southern California Local Union 831-Employer Health Fund, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Participants shall be entitled to:

Receive Information about Your Plan and Benefits

Examine, without charge, at the plan administrator's office and at other specified locations, such as work sites and union halls, all documents governing the plan, including insurance contracts and Collective Bargaining Agreements, and a copy of the latest annual report (Form 5500 Series) filed by the plan with the U.S. Department of Labor and available at the Public Disclosure Room of the Employee Benefits Security Administration.

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

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 you, your spouse or Dependents if there is a loss of coverage under the plan as the result of a qualifying event. You or your Dependents may have to pay for such coverage. Review this summary plan description and the documents governing the plan on the rules governing your COBRA continuation coverage rights.

You should be provided a certificate of creditable coverage, free of charge, from your group health plan or health insurance issuer when you lose coverage under the plan, when you become entitled to elect COBRA continuation coverage, when your COBRA continuation coverage ceases, if you request it before losing coverage, or if you request it up to 24 months after losing coverage. Although this plan does not have preexisting condition exclusions, if you lose coverage under this plan and are then covered by a plan that has a preexisting condition exclusion, without evidence of creditable coverage from this plan, you may be subject to a preexisting condition exclusion under your new plan for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Plan Fiduciaries

In addition to creating rights for 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 Participants. 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.

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, 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 frivolous.

Assistance with Your Questions

If you have any questions about your plan, you should contact the Fund Manager. 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 area office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue, N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

SECTION 22 GENERAL PROVISIONS

LEGAL ACTION/STATUTE OF LIMITATIONS

Legal action for recovery on a claim cannot be brought until at least 60 days after final notice of an adverse benefit determination has been provided by this Plan. Legal action cannot be brought following two years after the date a final adverse benefit determination is received by the Employee or Dependent. The forum for any legal action against the Health Fund or its Trustees is Los Angeles County, California, and the United States District Court for the Central District of California.

WORKERS' COMPENSATION

This Plan does not provide benefits required by Workers' Compensation or any similar law.

RESERVATION OF RIGHTS

While we anticipate that the Plan will remain in effect, the Trustees reserve the right, in their sole discretion, to amend, modify or terminate the Plan at any time. The Trustees specifically reserve the right to change, reduce, eliminate, or add to the benefits provided under the Plan, and may amend the eligibility rules applicable to all benefits. The continuance of the Plan is subject to the maintenance of Collective Bargaining Agreements which provide for Employer contributions to the Plan. No benefits or rules described in this booklet are guaranteed or vested. All benefits may be changed, reduced, or eliminated at any time by the Trustees of the Plan, in their sole discretion.

TERMINATION OF PLAN

If it ever becomes necessary to terminate the Plan, all assets then remaining in the Plan will be applied as set forth in the trust document establishing the Trust Fund.

DUAL COVERAGE PRECLUDED

No person, other than your spouse, can be covered under this Plan as both an Employee and a Dependent. If a Covered Person becomes eligible for benefits under this Plan while eligible for similar benefits due to a previous period of coverage under this Plan, this Plan will pay the greater benefit, but will not pay both.

OVERPAYMENT

If a benefit is paid under this Plan and it is later shown that a lesser amount should have been paid, this Plan will be entitled to a refund of the excess payment and will have the right to withhold future benefit payments until reimbursement of the excess payment is made to this Plan, and/or pursue legal and equitable remedies in Court.

INFORMATION REQUIRED

Every Participant shall furnish, at the request of the Trustees, any information or proof required for the administration of the Plan, or for the determination of any matter that the Trustees may

have before them. Failure to furnish such information or proof promptly and in good faith shall be sufficient reason for the denial of benefits to such Participant. The furnishing of fraudulent information or proof shall be sufficient reason for the denial, suspension, or discontinuance of benefits under the Plan, and, in such case, the Trustees shall have the right to recover any benefit payments made in reliance thereon.

FRAUD

Subject to the terms of the Patient Protection and Affordable Care Act (the "Affordable Care Act"), this Plan reserves the right to terminate coverage for you and/or your Dependent(s) if you and/or your Dependent(s) are otherwise determined to be ineligible for coverage. Pursuant to the Affordable Care Act, the coverage will not be rescinded retroactively, except in certain instances, such as if you or your covered Dependent(s) commits fraud or makes an intentional misrepresentation (for example, in enrollment materials, a claim, or appeal for benefits or in response to a question from the Plan Administrator or its delegates). In such cases of fraud or intentional misrepresentation, your coverage may be rescinded retroactively upon 30 days' notice. Failure to inform the Trust Fund Office that you or your Dependent is covered under another group health plan, and knowingly providing false information to obtain coverage for an ineligible Dependent are examples of actions that constitute fraud or intentional misrepresentations. Coverage may also be eliminated retroactively (without notice) in cases in which it would not be considered rescission under the Affordable Care Act, such as failure to pay a required premium or contribution toward the cost of coverage.

Examples of fraud against the Plan may also include your failure to notify the Trust Fund Office of your divorce; your acceptance of payment from an Employer for hours of work that should have been reported to the Plan but were not, where you knew or should have known that the Employer would not report the hours. Where a Participant is found to have engaged in fraud, the Plan may suspend or permanently discontinue coverage for the Participant.

GENERAL INFORMATION

Plan Name:	Southern California Local Union 831 - Employer Health Fund
Plan Administrator:	The Plan Administrator is the Board of Trustees of the Southern California Local Union 831 - Employer Health Fund, a joint board composed of an equal number of labor and management trustees. A complete list of the employers sponsoring this Plan may be obtained by Participants upon written request to the plan administrator and is available for examination by Employees and Dependents. Employees and Dependents may receive from the Plan administrator, upon written request, information as to whether a particular employer is a sponsor of this Plan and, if the employer is a Plan sponsor, the sponsor's address. The administration of this Plan is handled through an

	Administrative Manager who can be contacted at the following address and phone number: Trust Fund Office 1055 Park View Drive, Suite 111 Covina, CA 91724 (877) 572-7005 (626) 279-3080
Type of Plan:	This is a Health & Welfare Plan.
Plan Year:	January 1 to December 31.
IRS EIN (Employer Identification Number):	95-6047878
Plan Number:	501
Type of Plan:	This is a group health plan that provides Hospital, surgical, major medical, dental, optical, prescription drug, death, accidental death, and accidental dismemberment welfare benefits.
Plan Counsel:	Ronald Dean A Law Corporation 1155 Via de la Paz Pacific Palisades, CA 90272
Funding Method:	All funds are paid into this Plan pursuant to collective bargaining agreements or self-payments from Participants. A copy of any such collective bargaining agreement may be obtained by Employees and Dependents upon written request to the Plan Administrator and is available for examination by Employees and Dependents.
Union:	Trade Show & Sign Crafts Local Union 831 1155 Corporate Center Drive Monterey Park, CA 91754
Agent for Service of Legal Process:	Administrative Manager 1055 Park View Drive, Suite 111 Covina, CA 91724 Service of legal process may be made upon a Plan trustee or the Plan Administrator.

IMPORTANT TELEPHONE NUMBERS:

The Trust Fund Office .....(877) 572-7005 or
(626) 279-3080
www.localunion831trustfunds.com

Anthem Blue Cross .....(800) 274-7767 or
www.anthem.com

Optum Rx.....(800) 797-9791 or
www.optumrx.com

Kaiser Permanente (Multi-Lingual).....(800) 464-4000
(Spanish) .....(800) 788-0616
www.kp.org

Employee Assistance Program: Claremont EAP.....(800) 834-3773
https://www.claremonteap.com/help-request-form/ and use company name: Local 831

Si usted prefiere información en español acerca de este programa de seguro y sus clausulas, haga favor de comunicarse con la oficina de Fideicomiso, llamando al telefono (626)279-3080.