Multi Union Security Trust Fund

Fort Irwin

General Information Booklet

Summary Plan Description
Eligibility and Benefits

Effective September 1, 2011

AVISOS A LOS PARTICIPANTES DEL HABLA HISPANA

Si tiene preguntas respeto a lo contenido en este Resumen en *la* descripción del plan y se siente mas agusto hablando con alguien en Español, por favor llame a la oficina de Administradores al 1-800-753-0222 y pregunte por un representante de membrecia que hable Español

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TRUST ADMINISTRATION OFFICE:

Multi Union Security Trust Fund
1000 North Central Ave., Suite 400
Glendale, CA 91202
(818) 243-0222

FOREWORD

This Summary Plan Description has been prepared to give you basic information concerning the benefits available to you through the Multi Union Security Trust Fund. This booklet summarizes the benefit plans available to you and the procedures for review or appeal of claims. The booklet also provides information about the administration of the Trust and your rights under the law.

The benefits outlined in this booklet are available to you and your eligible Dependents (as outlined in the Eligibility section), provided you are working under the jurisdiction of a Collective Bargaining Agreement between your Employer and Union who participate in this Trust, or your coverage is provided pursuant to a Subscription Agreement between your Employer and the Trust. **EVERY COLLECTIVE BARGAINING AGREEMENT DOES NOT PROVIDE FOR ALL BENEFITS DESCRIBED IN THIS BOOKLET.** IF YOU HAVE ANY SPECIFIC QUESTIONS CONCERNING EITHER YOUR BENEFITS OR YOUR ELIGIBILITY, PLEASE CONTACT THE TRUST ADMINISTRATION OFFICE.

This booklet **does not** contain detailed information about the benefits provided by contract between the various benefit providers and the Trust. The provisions of each benefit are described in separate booklets available, free of charge, from the Trust Administration Office.

This booklet is being given general distribution to be certain everyone who is entitled to receive a copy does so. Because of this, you may receive a Summary Plan Description booklet whether or not you are currently eligible for benefits.

Various benefits summarized in this booklet are provided by the Trust in accordance with the terms of the policies and agreements issued by the following providers: PacifiCare (Prepaid Medical and Prescription Drug), Dental Health Services (Dental Plan), Aetna Life Insurance Company (Insured Life, Dependent Life and Accidental Death and Dismemberment Plan), Davis Vision (Vision Plan) and Managed Health Network (MHN) (Mental Health Program).

You are cautioned that no Employer or Union, nor any representative of any Employer or Union, is authorized to interpret the various insurance policies, agreements, or the coverage provided by these documents, nor can any such person act as an agent of the Trustees in any matter relating to these contracts, agreements, or coverage. Only the full Board of Trustees is authorized to interpret the Trust.

Accordingly, any questions you may have pertaining to your participation in the Multi Union Security Trust Fund should be directed to the Trust Administration Office, and are subject to final interpretations by the Trustees. Any questions regarding the specific benefits summarized in this book-

let should be directed to the appropriate Provider, and are subject to final interpretations by such Provider. A list of the Providers is contained later in this booklet.

REMEMBER, this booklet is only a summary of the plans available. If there is a conflict between this summary and any specific plan, the provisions of the specific plan govern.

NOTICE TO SPANISH SPEAKING PARTICIPANTS

If you have any questions concerning anything contained in this Summary Plan Description and feel more comfortable speaking Spanish, please call the Administrative Office at 1-800-753-0222 and request a Spanish-speaking Member Services Representative to discuss your questions.

The Board of Trustees intends to continue your health plan as long as sufficient Trust assets are available. However, the Board of Trustees reserves the sole right to change all or any of the plans from time to time, to discontinue all or any of the plans from time to time in the sole and absolute discretion of the Board of Trustees.

RELATIONSHIP BETWEEN THE TRUSTAND HEALTH CARE PROVIDERS AND INSURERS

No health-care provider or insurer is an agent or representative of the Trust. The Trust does not control or direct the provision of health-care services and/or supplies to employees and beneficiaries by anyone. The Trust makes no representation or guarantee of any kind concerning the skills or competency of any health-care provider. The Trust makes no representation or guarantee of any kind that any provider will furnish health-care services or supplies that are malpractice-free.

The foregoing statement applies to any and all health-care providers and all insurers (and their agents, employees, and representatives), which contract with the Trust to offer other health-related services or supplies to participants and beneficiaries, including, but not limited to PacifiCare, Dental Health Services, Davis Vision, Managed Health Network (MHN), and Aetna Life Insurance Company.

HEALTH CARE REFORM

The Patient Protection and Affordable Care Act (Affordable Care Act) was signed into law on March 23, 2010. The Affordable Care Act seeks to expand health coverage and provide you with certain rights regarding your health care. This law calls for changes to be made gradually over a period of years. The first set of changes to this Plan became effective on January 1, 2011, because that is the first day of the plan year beginning on or after September 23, 2010. As of January 1, 2011, the Plan's various benefit packages are "grandfathered." A plan is considered a grandfathered plan if the benefits were in effect on March 23, 2010, at least one participant was enrolled in the plan, and the plan has not made certain types of changes that would otherwise cause it to lose grandfathered status.

This booklet contains important information about changes that are required by the Affordable Care Act. As other changes occur, you will receive additional notices which should be kept with this booklet for your reference.

DEFINITIONS

Actively at Work means performing your job for the Contributing Employer pursuant to the Collective Bargaining Agreement.

Board of Trustees means the plan sponsor, administrator, and fiduciary of this Trust who has exclusive authority and discretion to manage the assets of the Trust.

Collective Bargaining Agreement means the collective bargaining agreements between the Employers and Union which provide for contributions to the Trust (also referred to as **Subscription Agreement** for those Employees not covered by a collective bargaining agreement).

Contributing Employer means an Employer who is required by a Collective Bargaining Agreement or Subscription Agreement to make contributions to the Multi Union Security Trust Fund.

Dependent means those eligible Dependents of the Employee as specified on pages 2 - 3 of the Eligibility section of this booklet.

Employee means any Employee who is Actively at Work while maintaining the eligibility requirements in order to receive coverage under the Trust according to the provisions of the Collective Bargaining Agreement.

Evidence of Coverage means the booklet provided by your HMO, vision, dental, life and AD&D provider describing the terms and benefits of these plans.

HMO Identification Card means the card issued to you by your HMO that identifies you as a Member of their Plan.

Inpatient means an Employee or Dependent who is confined in a Hospital or a Convalescent or Skilled Nursing Facility and is charged for Room and Board.

Member means a person who is eligible for Medical Plan benefits.

Open Enrollment Period is the period in which you can select a different medical and dental provider, but only once in any twelve-month period.

Provider means the carriers or providers of service to the Trust as listed on page 24 of this booklet.

Qualifying Event means an event which qualifies an Employee or Dependent for continuation of benefits coverage under the Consolidated Omnibus Reconciliation Act (COBRA) of 1985.

Sickness means illness or disease.

Trust means Multi Union Security Trust Fund (also referred to as **Plan**).

Trust Administration Office means the administrative office of Multi Union Security Trust Fund, located at: 1000 North Central Ave., Suite 400, Glendale, California, 91202.

Trust Agreement is the agreement that spells out the governance of the Trust and the methods of receipt, investment and disbursement of funds under the Trust.

Union means a Union that is signatory to a Collective Bargaining Agreement that provides participation in the Multi Union Security Trust Fund.

ELIGIBILITY

Employees

Initial Eligibility

Eligibility for individual participants shall be determined according to the provisions of the Collective Bargaining Agreements between the various Unions and Employers participating in the Trust. The Trustees are empowered to create and enforce the rules pertaining to individual eligibility. The Trustees, in exercising their responsibilities, reserve the right to modify any eligibility requirements without prior notice. Please refer to your Collective Bargaining Agreement to determine the eligibility rules that apply to you or contact the Trust Administration Office.

Enrollment for Benefits

Please refer to your Collective Bargaining Agreement to determine the medical and dental plans available to your group, or contact the Trust Administration Office. When you select the medical plan you want for yourself and your family, you must also complete the appropriate HMO enrollment form, which is supplied by your Employer or the Trust Administration Office. Coverage will become effective the first of the month after the date you become eligible.

You cannot be properly enrolled for benefits until the Trust Administration Office receives the appropriate HMO enrollment form. Therefore, if your Employer fails to provide you with the enrollment package, you should ask for it. If your Employer cannot provide the enrollment package, contact the Trust Administration Office immediately. Coverage may be denied if the appropriate HMO enrollment form is not received by the Trust Administration Office within 30 days from the date you become eligible.

Continuing Eligibility

After you establish Initial Eligibility, you remain eligible as long as you continue to satisfy the eligibility rules required to maintain your coverage, as provided in your Collective Bargaining Agreement. Please refer to your Collective Bargaining Agreement to determine these eligibility rules or contact the Trust Administration Office.

Termination of Employee Eligibility

Your coverage will terminate on the earliest of the following dates:

1) You fail to satisfy the eligibility rules required to maintain your coverage, as provided in your Collective Bargaining Agreement; or
2) The date you enter full-time military service; or
3) The date coverage for which you are eligible is eliminated from the Trust.

Military Leave of Absence

If you are on a military leave of absence from your employment, and the period of military leave is less than thirty-one (31) days, you will continue to be eligible for coverage under the Trust during the thirty (30) day leave with no self-payment required, provided you are in an eligible status under this Trust at the time your military leave begins.

If you are on a military leave of absence from your employment, and the period of military leave is at least thirty-one (31) days and up to 24 months, your may continue your health coverage for up to 24 months by paying the full contribution, in addition to any administrative costs of up to 2%, to the Fund Administrator. How you may self-pay to continue your health coverage is set forth more fully in the Section entitled, "Continuation of Coverage Under Federal Law ('COBRA')."

Upon release from active service, your eligibility may be reinstated in accordance with the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) described later in this Summary Plan Description.

Plan Opt Out Rule

The Trust permits opt-outs in very limited circumstances. Only when an employee and his spouse are both covered by the Trust and are employed by signatory contractors to the Trust, may an employee opt out of medical, dental, and vision coverage as an employee, **but he must still be covered as a dependent for such benefits under this Trust**. However, for mental health coverage and life insurance, the employee may **not** opt out and must be covered for such benefits as an employee.

Dependents

Initial Eligibility

Once an Employee qualifies for Eligibility (Initial and Continuing Eligibility), eligible Dependents are also entitled to the benefits provided by the Trust, as long as the Employee remains eligible. Eligible Dependents will be covered under the same Medical, Vision, Dental, Mental Health and Life Insurance programs selected by the Eligible Employee. There is no Accidental Death and Dismemberment Benefit for Dependents.

All eligible Dependents must be enrolled, including newly-acquired Dependents (and newborn children). Services and reimbursement can be delayed or denied to Dependents who are not properly enrolled. You may obtain the necessary forms to enroll newly-acquired Dependents from your Employer or the Trust Administration Office. Coverage may be denied if the necessary forms are not received by the Trust Administration Office within 30 days from the date your dependent becomes eligible.

Eligible Dependents are your:
(1) wife or husband; (2) Domestic Partner, (3) the Participant's children, including adopted children, and stepchildren, under the age of 26, provided the covered child is not eligible for their own or their spouse's employer-sponsored health coverage.

An unmarried dependent child over age 26, who is incapable of supporting him/herself because of mental or physical disability which began prior to age 26, will continue to qualify as an eligible De-

pendent as long as the child remains disabled, unmarried, and is dependent on the Employee for support and maintenance. Proof of such incapacity and dependency must be furnished to the Trust and/or provider(s) upon request. Disabilities that occur after your child is no longer eligible are not covered.

*****The term "registered domestic partner" means an individual with whom you have a legal registered domestic partnership as defined under the laws of California, or as recognized under the laws of another state or of a local jurisdiction of another state.

The term "dependent" does not include a person who is on active duty in any armed forces.

As long as the benefit package under which you are covered is "grandfathered" under health care reform, the Fund will deny eligibility to your dependents from ages 19 up to 26 if they are eligible for their (or their spouse's) employment-based health plan.

Termination of Dependent Eligibility

Dependent Eligibility will terminate upon the earlier of the following dates:

1) When the Employee ceases to be eligible, or;
2) The date the Dependent, as defined by the Trust, no longer qualifies as an eligible Dependent, or;
3) The date the Dependent enters into full-time military, naval, or air service, or;
4) In the event of a divorce, your spouse's eligibility will terminate when the final decree is issued.
5) The date the Trustees terminate coverage for dependents.

However, when the Dependent's eligibility terminates, the Dependent may have the right to elect COBRA coverage under the Trust. See page 5 for more information about COBRA rights.

QUALIFIED MEDICAL CHILD SUPPORT ORDER (QMCSO)

The Trust recognizes Qualified Medical Child Support Orders and will enroll any child of a Trust participant as directed by the Order. A Qualified Medical Child Support Order is any judgment, decree, or order (including approval of a settlement agreement) issued by a court which:

- provides the child of a Trust participant with health benefits under the Trust; or

- enforces a state law relating to medical child support, which provides in part that if the employee parent does not enroll the child, the non-employee parent or State agency may enroll the child.

To be qualified, a Medical Child Support Order must clearly specify:

- the name and last known mailing address of the participant and the name and mailing address of each child covered by the order;

- a reasonable description of the type of coverage to be provided by the Plan to each such child, or the manner in which such type of coverage is to be determined; and

- the period to which such Order applies.

In addition, a properly completed National Medical Support Notice will be deemed to be a Qualified Medical Child Support Order.

Upon receipt of a Medical Child Support Order, the Trust Administration Office will review the Order to verify that it meets the legal requirements. The Trust Administration Office will make such a determination within a reasonable period and notify the participant and each child of the determination. If the Order is a qualified Order, the child will be enrolled in the Plan.

Any payment for benefits by the Trust under the Medical Child Support Order to reimburse expenses advanced by an alternate recipient, or his/her custodial parent or legal guardian, shall be made to the alternative recipient or his/her custodial parent or legal guardian.

NOTE: A Dependent will be eligible for coverage only if his or her full name, date of birth, Social Security number and relationship to the Employee have been provided to the Trust Administration Office by submitting a completed enrollment form.

FAMILY AND MEDICAL LEAVE ACT (FMLA)

Under the Family and Medical Leave Act (FMLA), your employer must continue to pay for your health coverage during any approved leave. In general, you may qualify for up to 12 weeks of unpaid FMLA leave each year if*:*

1. Your employer has at least 50 employees;

2. You worked for the employer for at least 12 months and for a total of at least 1,250 hours during the most recent 12 months; and

3. You require leave for one of the following reasons:

    a. Birth or placement of a child for adoption or foster care,

    b. To care for your child, spouse or parent with a serious medical condition, or

    c. Your own serious health conditions.

    The FMLA also permits an employee to take up to 26 weeks of leave to care for a spouse, son, daughter, parent, or next of kin, who is a: (1) member of the Armed Forces, including a member of the National Guard or Reserves, who is undergoing medical treatment, recupera-

tion, therapy, is otherwise in outpatient status, or is otherwise on a temporary disability retired list, for a serious injury or illness; or (2) veteran within the meaning of the FMLA. An employee is permitted to take up to 12 weeks of FMLA leave for "any qualifying exigency" (as defined by the Secretary of Labor) for his spouse, son, daughter, or parent, who is deployed with the Armed Forces to a foreign country.

Your employer is required to maintain your health coverage during the 12-week or 26-week period as the case may be.

You must contact your Employer to determine if you are eligible for FMLA leave. It is not the role of the Trustees or the Trust Administration Office to make this determination.

CONTINUATION OF COVERAGE UNDER FEDERAL LAW (COBRA)

If Eligibility under the Trust terminates due to one of the following Qualifying Events, Employees and Dependents who were covered by the health care plans on the day before the Qualifying Event have the right to continue health coverage (Medical, Vision and Dental benefits), under a federal law known as "COBRA." These qualifying events are:

1) Termination of employment (due to quit, discharge, lay-off or for reasons other than gross misconduct) or reduction in your covered hours of employment);
   (Note that your employment may terminate or your covered hours may be reduced, if you take a leave of absence, retire, or become disabled).
2) Death of spouse or parent (in the case of a Dependent);
3) Your divorce or legal separation;
4) Loss of status as a Dependent child;
5) Entitlement to Medicare (in the case of a Dependent) if it results in a loss of the Dependent's group health coverage.

Employees and Dependents will be required to pay for the continued health coverage at group rates, which are higher than the group rates for Employees who are employed under the various Collective Bargaining Agreements (up to 102% of the premium cost for the first 18 months of continued coverage and up to 150% after the 18th month of continued coverage in the case of a disability extension).

If employment has been reduced or terminated (item 1 above), you and your Dependents are entitled to 18 months of continued coverage under the Trust from the date of your loss of eligibility under the Trust due to the Qualifying Event. Each of the other listed events (items 2 through 5) entitles eligible Dependents to 36 months of continued coverage from the date of the loss of eligibility due to such Qualifying Event. If the Dependent has continued coverage because of the Employee's termination or reduction in hours (item 1 above), the Dependent may extend coverage from 18 months (29 months, if disabled as described below) up to a maximum of 36 months, if a second qualifying event (items 2 through 5) occurs during the first 18 (or 29) month coverage period.

If you, the Employee, become entitled to Medicare (even if that event is not a Qualifying Event), the maximum period of coverage for your Dependents for such event, or for any subsequent Quali-

fying Event is the 36-month period beginning on the date that the Employee becomes entitled to Medicare.

Extended Continuation Coverage for Disabled Individuals

If you are entitled to 18 months of continuation coverage and if you are determined to be disabled under the terms of the Social Security Act at any time during the first 60 days of COBRA continuation coverage, you are eligible for up to an additional 11 months of continuation coverage after the expiration of the 18 month period. To qualify for this additional period of coverage, you must notify the Trust Administration Office in writing within 60 days after you receive a determination of disability from Social Security Administration, provided written notice is given before the end of the initial 18 months of continuation coverage. You must also notify the Trust in writing within 30 days of the final Social Security determination indicating you are no longer disabled. During the additional 11 months of continuation coverage, your premium will be approximately 50% higher than it was during the first 18 months. However, if you, the disabled individual, do not elect COBRA coverage, the cost for electing Dependents will not be more than was permitted to be charged in the first 18 months of continuation coverage (i.e., 102% of the premium cost).

Cost of COBRA Continuation Coverage

As previously mentioned, the coverage required by law is available **only at your own expense**. If you or your Dependent(s) elect to continue coverage, the full cost, plus an administrative charge, will be charged.

Life and Accidental Death and Dismemberment Benefits are not included under the COBRA Continuation of Coverage law.

Election of COBRA Continuation Coverage

You or your Dependents must elect to continue coverage within 60 days following receipt of a COBRA notice and election form from the Trust Administration Office advising of COBRA Continuation of Coverage, or within 60 days following the date Employee or Dependent coverage would terminate, whichever is later.

If the Qualifying Event is divorce or legal separation from the Employee or a child's loss of Dependent status, the Employee or Dependent must notify the Trust Administration Office in writing within 60 days after the later of the date of the applicable qualifying event or the date coverage under the group health plan would otherwise end. Group health coverage would otherwise end as of the date of the loss of coverage due to the qualifying event unless COBRA continuation coverage is elected.

The initial premium, which must include premiums due from the date your Eligibility would have terminated, must be paid to the Trust Administration Office within 45 days following submission of the COBRA election form.

You or your Dependents are also responsible for sending in payments for required monthly premiums in full and on the premium due date, as established by the Trust Administration Office. If

any premiums are not received within 30 days of the due date, eligibility for the COBRA Continuation of Coverage will terminate.

COBRA continuation coverage is only available to Employees and/or Dependents who were covered under the health plans on the day before the Qualifying Event, except that a child who is born to or placed for adoption with the covered Employee during the period of COBRA continuation coverage will also be eligible, provided that the covered Employee elects COBRA continuation coverage for himself during the election period and elects coverage for the child within 30 days of the child's birth or placement for adoption.

Open Enrollment Under COBRA Continuation of Coverage

During Open Enrollment you may add or delete dependents from your coverage. Please obtain the add/delete forms from your company office or from the Trust Administrator.

Termination of COBRA Continuation of Coverage

Eligibility for COBRA Continuation of Coverage will terminate on the first day of the month following the occurrence of any one of the events listed below:

1) Failure to remit the required premium payment in full and on time (not later than 30 days following the due date established by the Trust Administration Office, or no later than 45 days following submission of the initial COBRA election form).
2) You or your eligible Dependents, who have previously elected to continue coverage under this Trust, become covered, as an Employee or as a Dependent, under any other group health plan, provided, however, that if the successor group health plan excludes coverage for a pre-existing condition, you may continue COBRA coverage as long as the successor plan's pre-existing condition applies to you (but not beyond the end of the maximum COBRA coverage period as described above).
3) You or your Dependents, who have previously elected to continue coverage under this Trust, become entitled to Medicare (under Part A, Part B, or both);
4) The date the Multi Union Security Trust Fund ceases to provide group health coverage to any Employees.
5) You or your Dependents have continued coverage for additional months due to a disability, and there has been a final determination by Social Security that you or your Dependents are no longer disabled. (In this case, coverage ends on the first of the month that begins more than 30 days after the Social Security Administration makes a final determination that you or your Dependent are no longer disabled after the initial 18-month period).
6) For any reason (such as fraud or intentional misrepresentation) for which the Fund would terminate coverage of an individual otherwise receiving coverage under the Fund
7) You reach the end of your maximum COBRA continuation coverage period as described above.

If you relocate to an area not covered by the PacifiCare, alternative coverage may not be available. If the Trust offers other coverage to Employees that is available in, or can be executed to, your new location, you may elect to receive that coverage (some restrictions apply). However, COBRA continuation coverage will not be provided to you if coverage (offered to Employees) is not available in the area to which you relocate.

California COBRA Option

If you have a qualifying event that results in less than 36 months of coverage, and you have maintained that coverage for the maximum period of time, you may be eligible to continue your medical benefits for an additional period of time under California COBRA. You can receive additional information from the HMO.

Conversion Option

NOTE: Once COBRA Continuation of Coverage terminates, you or your Dependents (if eligible) may have the right to convert health insurance (medical only) to conversion coverage under the Right to Convert Health Insurance provisions provided by PacifiCare. You must check the appropriate HMO Evidence of Coverage booklet for details regarding Conversion to Individual Plan Coverage.

To summarize, you may have conversion rights with their HMO or Cal-COBRA self pay rights. Contact your HMO to find out what those rights are or contact the Trust Administration Office at 1-800-753-0222.

Rights Under USERRA

This section provides information about your rights under the Uniformed Services Employment and Reemployment ACT ("USERRA").

Congress enacted USERRA to provide protections to individuals who are members of the "uniformed services." "Uniformed services" is defined as the Armed Forces, the Army National Guard and the Air National Guard when engaged in active duty for training, inactive duty training, or full-time National Guard duty, the commissioned corps of the Public Health Services, and any other category of persons designated by the President in time of war or national emergency. One of the protections provided by USERRA is that Employees covered under a group health plan must be given an opportunity to elect to continue coverage for themselves and/or their dependents (other than a domestic partner who does not qualify as a dependent under Internal Revenue Code Section 152) if they take leave to serve in the uniformed services (hereinafter "military leave").

The maximum period of continuation coverage for health care under USERRA is the lesser of: (1) 24 months (beginning from the date you leave work due to your military leave) or (2) the day after the date you fail to timely apply for or return to a position of employment with an Employer participating in the Trust.

If you elect continuation coverage, the COBRA and USERRA continuation periods will run concurrently.

Generally, your right to continuation coverage is governed by COBRA, as described above. However, in the event you choose continuation of coverage, you have the same additional rights under USERRA. The first additional right is set forth above on page 5, which applies if your military leave of absence from employment is less than 31-days. Second, if you or your Dependents become covered by another group health plan or entitled to Medicare during the USERRA maximum coverage period described above, the Trust will not terminate the continuation coverage elected by you and your Dependents.

Notice of Medi-Cal Health Insurance Premium Program (HIPP)

If you are eligible for Medi-Cal, you may qualify for the Health Insurance Premium Payment Program (HIPP). Under this program the California Department of Health Services will pay your COBRA premium for you. To be eligible for this program you must:

- be Medi-Cal eligible;
- have a high cost medical condition (e.g. pregnancy, HIV/AIDS, organ transplants);
- have either a current private health coverage policy or access to health coverage through an employer (includes COBRA and Cal-COBRA, but excludes policies issued through the California Managed Risk Medical Insurance Board (MRMIB). ***Note: The policy must not exclude coverage for the beneficiary's specific high cost medical condition.**
- not be enrolled in a Medi-Cal managed care plan; and
- not be enrolled in a county organized health plan.

In addition, if you are unable to work because of disability due to HIV/AIDS you may qualify if you have a total monthly income less than the percentage allowed under the HIPP provisions of the poverty level established by the federal government. To enroll in HIPP or to find out more information about the requirements for enrollment, call **1-866-298-8443** or visit the website at http://www.disabilitybenefits101.org/ca/programs/health_coverage/premium_payment/medi_cal_hipp/ .

YOUR MEDICAL PLAN

As a new Employee, when you become eligible for coverage for the first time, you **must** complete the appropriate HMO enrollment form in full and select a Primary Care Physician from the appropriate HMO provider directory. This medical plan is described in a separate booklet called Evidence of Coverage. The Evidence of Coverage booklet and the HMO provider directory for PacifiCare can be obtained, free of charge, by contacting the Trust Administration Office.

It is important you send the completed enrollment form to the Trust Administration Office. Your eligible Dependent(s) will be covered under the same medical plan you select for yourself. Services can be delayed or denied unless you have made your selection in writing, and all the required information has been correctly filled in, including Social Security numbers for each of your enrolled Dependents. The Evidence of Coverage booklet for each plan contains the insuring provisions, including applicable limitations and exclusions for each program. If you have any questions regarding your medical plan coverage, please contact the Trust Administration Office before incurring any expenses.

Health Maintenance Organization (PacifiCare)

A health maintenance organization (HMO) offers comprehensive medical care from a group of providers under contract to the HMO. In an HMO, you must select a physician from among those employed by or under contract to the HMO. However, covered services and supplies are provided by

the HMO facilities either at no cost to you or with minimal copayments. Further, there are no claim forms to file.

Except for certain medical emergencies or authorized referrals, you must use physicians or hospitals affiliated with the HMO. If you do not use physicians or hospitals authorized by your HMO, neither the Trust nor the HMO will be responsible for the charges you incur.

PacifiCare is the HMO plan currently available. To enroll in this HMO plan, you must live within the service area of the HMO. If you do not reside within any of the HMO service areas, please contact the Trust Administration Office.

Open Enrollment Period

You have the option to add or delete dependents under the terms of your collective bargaining agreement at any time during the Open Enrollment Period, but only once during a specified period during the year. As previously mentioned under COBRA continuation coverage, additional information concerning the Trust's Open Enrollment Period will be provided during the month preceding the Open Enrollment Period for your group. Changes are effective the first day of the month following the date the Trust Administration Office receives the appropriate HMO enrollment form. If you do not wish to add or delete dependents, you do not need to do anything.

You must complete the enrollment/change form indicating the change in coverage. This form will be supplied by your Employer or the Trust Administration Office. Services can be delayed or denied unless you have made your selection in writing, and all the required information has been correctly filled in and submitted to the Trust Administration Office within 30 days from the date you are eligible to change your medical plan. The Trust Administration Office can provide you with information regarding the medical benefits provided by PacifiCare.

If you move, or are no longer in the service area of the HMO, you should notify the Trust Administration Office. Further information concerning the Trust's Open Enrollment Period will be mailed by the Trust Administration Office.

LEGISLATION AFFECTING HEALTH CARE BENEFITS

Newborn & Mother's Health Protection Act of 1996

Group health plans and health insurance issuers generally may not, under federal law, restrict benefits for any hospital length of stay in connection with childbirth for you or your newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, federal law generally does not prohibit your or your newborn's attending provider, after consulting you, from discharging you or your 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 obtains authorization from the plan or the issuer for prescribing a length of stay that is less than 48 hours (or 96 hours).

In addition, under California law, if the attending provider, after consulting with the mother, discharges the mother or her newborn earlier than 48 hours (or 96 hours), the group health plan must cover a post-discharge visit for the mother and newborn within 48 hours of discharge when pre-

scribed by the treating physician. The visit shall be provided by a licensed health care provider whose practice includes postpartum care and newborn care and shall include at a minimum, parent education, assistance and training in bottle feeding and the performance of any necessary maternal or neonatal physical assessments. The treating physician shall determine, after consulting with the mother, whether the post-discharge visit shall occur at home, the Plan's facility or the treating physician's office after assessment of certain factors including the transportation needs of the family and environmental and social risks.

Women's Health and Cancer Rights Act of 1998

The Women's Health & Cancer Rights Act of 1998 requires that if your health plan provides medical and surgical benefits for a mastectomy, and if you were to need a mastectomy, you would also be covered for:

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

Health Insurance and Portability and Accountability Act (HIPAA)

Changes in federal law may affect your health coverage if you are enrolled or become eligible to enroll in health coverage that excludes coverage for preexisting medical conditions. The Health Insurance Portability and Accountability Act of 1996 (HIPAA) limits the circumstances under which coverage may be excluded for medical conditions present before you enroll. If you are age 19 years or older, a preexisting condition may not be excluded from coverage for more than 12 months (or 18 months if you don't enroll at your first opportunity). The 12-month (or 18-month) exclusion period is reduced by your prior health coverage and you are entitled to a certificate that shows evidence of your prior health coverage. If you have 12 months of continuous coverage under the Trust, your new health care plan cannot exclude your preexisting conditions from coverage, except under the following situations:

- if you do not enroll at your first opportunity, in which case the new health care plan can exclude your preexisting conditions up to 18 months; and
- if you have a lapse in coverage lasting 63 days or longer. A 63-day lapse in coverage has the effect of erasing all creditable coverage.

When your coverage under the Trust ends, you are entitled to a Certificate of Creditable Coverage that shows you were covered under a medical benefit program, and the length of time you were covered. You should automatically receive a Certificate of Creditable Coverage. If you do not receive this certificate, contact the Trust Administration Office.

Certificate of Creditable Coverage

If you or your Dependent lose coverage under the Trust, you will be furnished with a Certificate of Creditable Coverage. You may need the certificate if your new plan excludes coverage for pre-

existing conditions. If you are entitled to COBRA coverage, the certificate will be mailed when a notice for a qualifying event under COBRA is required, and after COBRA coverage ends. You also may request a certificate at any time within 24 months after your coverage ends.

HIPAA Special Enrollment

If an Employee declines enrollment for an eligible dependent(s) because the dependent is covered under another group health plan, the dependent may be eligible to be enrolled in this Trust in the future, provided that enrollment in the Trust is requested within 30 days after the other coverage ends.

HIPAA also requires the Trust to make certain special enrollment rights available to a new dependent(s) added through marriage, birth, adoption, or placement for adoption. At the same time, you may add you and/or your existing dependents who are not currently in the Trust, but only if:

1. You and/or your new dependent(s) and existing dependent(s), if applicable, are otherwise eligible to enroll under the terms of the Trust and the requested benefit option and your Collective Bargaining Agreement allows for employee and dependent coverage; and
2. You request enrollment of you and/or your dependent(s) no later than 30 days after the date that the new dependent(s) becomes a dependent(s) by marriage, birth, adoption or placement for adoption; and
3. Your employer has made the required contributions.

If the conditions set out in (1), (2) and (3) above are met, coverage in the Trust will begin in the case of marriage, no later than the first calendar month beginning after the date the Trust receives the request for special enrollment and the Trust has received enrollment forms that are complete. In the case of birth, adoption, or placement for adoption, coverage will begin on the date of birth, adoption, or placement for adoption, respectively; however, you will need to complete the Trust's enrollment forms as soon as possible, but no later than the 30 days following the event.

However, if you do not add yourself and/or your dependent(s) within the time frame described above, no special enrollment rights are available to you and/or your dependent(s). You can enroll yourself and/or your dependent(s) during the Trust's Open Enrollment Period each year, if you and/or your dependent(s) are otherwise eligible, you complete the required enrollment forms, and your employer makes the required contributions.

Children's Health Insurance Program Reauthorization Act

Under the Children's Health Insurance Program Reauthorization Act of 2009 (CHIPRA), group health plans must offer new special enrollment opportunities. Plans must permit employees and dependents who are eligible for, but not enrolled in, a group health plan to enroll in the plan upon:

- losing eligibility for coverage under a State Medicaid or CHIP program; or
- becoming eligible for State premium assistance under Medicaid or CHIP.

The employee or dependent must request coverage within 60 days of being terminated from Medicaid or CHIP coverage or within 60 days of being determined to be eligible for premium assistance.

Individuals need to contact their State's Medicaid or CHIP program to determine if they are eligible for Medicaid or CHIP, and to see if their State will subsidize group health plan premiums. If they are eligible for a premium subsidy, they need to contact the Trust Administration Office at 1-800-753-0222 to take advantage of the new special enrollment opportunity and enroll in the group health plan.

Those individuals who have additional questions can also call the U.S. Department of Labor at 1-866-444-3272 (EBSA) to speak to a Benefits Advisor.

HIPAA Privacy Rights

The Trust is required by law to maintain the privacy of your health information. The Trust must provide you with its explanation of its privacy policy and procedures, as outlined below, on its legal duties and privacy practices with respect to your health information. The Trust is also required to abide by the terms of its privacy policy and procedures, which may be amended from time to time.

How The Trust May Use Or Disclose Your Health Information: The Trust is permitted by law to use or disclose your "health information" to conduct activities necessary for "payment" and "health care operations." These are the main purposes for which we will use or disclose your health information. For each of these purposes, the list below shows examples of these kinds of uses and disclosures. These are only examples and are not intended to be a complete list of all the ways the Trust may use or disclose your health information.

Payment: The Trust may use or disclose health information about you for purposes within the definition of "payment." These include, but are not limited to, the following purposes and examples:

- **Determining your eligibility for plan benefits.** For example, the Trust may use information obtained from your employer to determine whether you have satisfied the Plan's requirements for active eligibility.
- **Obtaining contributions from you or your employer.** For example, the Trust may send your employer a request for payment of contributions on your behalf, and we may send you information about premiums for COBRA continuation coverage.
- **Pre-certifying or pre-authorizing health care services.** For example, the Trust may consider a request from you or your physician to verify coverage for a specific hospital admission or surgical procedure.
- **Determining and fulfilling the Plan's responsibility for benefits.** For example, the Trust may review health care claims to determine if specific services that were provided by your physician are covered by the plan.
- **Providing reimbursement for the treatment and services you received from health care providers.** For example, the Trust may send your physician a payment with an explanation of how the amount of the payment was determined.
- **Subrogating health claim benefits for which a third party is liable.** For example, the Trust may exchange information about an accidental injury with your attorney who is pursuing reimbursement from another party.

- **Coordinating benefits with other plans under which you have health coverage.** For example, the Trust may disclose information about your plan benefits to another group health plan in which you participate.
- **Obtaining payment under a contract of reinsurance.** For example, if the total amount of your claims exceed a certain amount, the Trust may disclose information about your claims to our stop-loss insurance carrier.

Health Care Operations: The Trust may use and disclose health information about you for purposes within the definition of "health care operations." These purposes include, but are not limited to:

- **Conducting quality assessment and improvement activities.** For example, a supervisor or quality specialist may review health care claims to determine the accuracy of a processor's work.
- **Case management and care coordination.** For example, a case manager may contact home health agencies to determine their ability to provide the specific services you need.
- **Contacting you regarding treatment alternatives or other benefits and services that may be of interest to you.** For example, a case manager may contact you to give you information about alternative treatments which are neither included nor excluded in the plan's documentation of benefits but which may nevertheless be available in your situation.
- **Contacting health care providers with information about treatment alternatives.** For example, a case manager may contact your physician to discuss moving you from an acute care facility to a more appropriate care setting.
- **Employee training.** For example, training of new claims processors may include processing of claims for health benefits under close supervision.
- **Accreditation, certification, licensing, or credentialing activities.** For example, a company that provides professional services to the plan may disclose your health information to an auditor that is determining or verifying its compliance with standards for professional accreditation.
- **Securing or placing a contract for reinsurance of risk relating to claims for health care.** For example, your demographic information (such as age and sex) may be disclosed to carriers of stop loss insurance to obtain premium quotes.
- **Conducting or arranging for legal and auditing services.** For example, your health information may be disclosed to an auditor who is auditing the accuracy of claim adjudications.
- **Management activities relating to compliance with privacy regulations.** For example, the Privacy Officer may use your health information while investigating a complaint regarding a reported or suspected violation of your privacy.
- **Resolution of internal grievances.** For example, your health information may be used in the process of settling a dispute about whether or not a violation of the Trust's privacy policies and procedures actually occurred.

In addition to the circumstances and examples described above, the Trust will disclose health information about you to the Board of Trustees for purposes of treatment, payment and health care operations. For example, the Trust may disclose health information about you in order to decide an appeal or to evaluate a suspected or actual fraudulent claim.

Other Uses and Disclosures: The following categories describe other ways that the Trust may use and disclose your health information. Each category is illustrated with one or more examples. Not

every potential use or disclosure in each category will be listed, and those that are listed may never actually occur.

- **Involvement in Payment**. With your agreement, the Trust may disclose your health information to a relative, friend, or other person designated by you as being involved in payment for your health care. For example, if we are discussing your health benefits with you, and you wish to include your spouse or child in the conversation, we may disclose information to that person during the course of the conversation.
- **Required by Law**. The Trust will disclose your health information when required to do so by federal, state, or local law. For example, the Trust may disclose your information to a representative of the U.S. Department of Health and Human Services, who is conducting a privacy regulations compliance review.
- **Public Health**. As permitted by law, the Trust may disclose your health information as described below:
    1. **To an authorized public health authority**, for purposes of preventing or controlling disease, injury or disability;
    2. **To a government entity** authorized to receive reports of child abuse or neglect;
    3. **To a person under the jurisdiction of the Food and Drug Administration**, for activities related to the quality, safety, or effectiveness of FDA-regulated products.
- **Health Oversight Activities**. The Trust may disclose your health information to health agencies during the course of audits, investigations, inspections, licensure and other proceedings related to oversight of the health care system or compliance with civil rights laws. However, this permission to disclose your health information does not apply to any investigation of you which is directly related to your health care.
- **Judicial and Administrative Proceedings**. The Trust may disclose your health information in the course of any administrative or judicial proceeding:
    1. In response to an order of a court or administrative tribunal, or
    2. In response to a subpoena, discovery request, or other lawful process.
    3. Specific circumstances may require us to make reasonable efforts to notify you about the request or to obtain a court order protecting your health information.
- **Law Enforcement.** The Trust may disclose your health information to a law enforcement official for various purposes, such as identifying or locating a suspect, fugitive, material witness or missing person.
- **Coroners, Medical Examiners and Funeral Directors.** The Trust may disclose your health information to coroners, medical examiners and funeral directors. For example, this may be necessary to identify a deceased person or determine the cause of death.
- **Organ and Tissue Donation.** The Trust may disclose your health information to organizations involved in procuring, banking or transplanting organs and tissues, to facilitate such.

In no event will the Trust use or disclose your PHI that is "genetic information" for "underwriting" purposes, as such terms are defined by the Genetic Information Nondiscrimination Act of 2008.

Except as described above, the Trust will not use or disclose your health information without written authorization from you. If you have authorized the Trust to use or disclose your health information for another purpose, you may revoke your authorization in writing at any time. If you revoke your authorization, the Trust will no longer be able to use or disclose health information about you for the reasons covered by your written authorization. However, the Trust will be unable to take

back any disclosures the Trust has already made with your permission. Requests to revoke a prior authorization must be submitted in writing. Please direct your written request to revoke prior authorization to:

Privacy Officer
PacFed Benefit Administrators, Inc.
1000 North Central Ave., Suite 400
Glendale, CA 91202
Phone: (818-243-0222

If you would like to obtain a more detailed explanation of these rights, or if you would like to exercise one or more of these rights, please contact the Trust Administration Office.

Right to Request Restrictions: You have the right to request restrictions on certain uses and disclosures of your health information. The Trust is not required to agree to restrictions that you request. If you would like to make a request for restrictions, you must submit your request in writing to the Privacy Officer at the above address.

Right to Request Confidential Communications: You have the right to ask the Trust to communicate with you using an alternative means or at an alternative location. Requests for confidential communications must be submitted in writing to the Privacy Officer at the above address. The Trust is not required to agree to your request unless disclosure of your health information could endanger you.

Right to Inspect and Copy: You have the right to inspect and copy health information about you that may be used to make decisions about your plan benefits. To inspect or copy such information, you must submit your request in writing to the Privacy Officer at the above address. If you request a copy of the information, the Trust may charge you a reasonable fee to cover expenses associated with your request.

Right to Request Amendment: If you believe that the Trust possesses health information about you that is incorrect or incomplete, you have a right to ask the Trust to change it. To request an amendment of health records, you must make your request in writing to the Privacy Officer at the above address. Your request must include a reason for the request. The Trust is not required to change your health information. If your request is denied, the Trust will provide you with information about its denial and how you can disagree with the denial.

Right to Accounting of Disclosures: You have the right to receive a list or "accounting" of disclosures of your health information made by us. However, the Trust does not have to account for disclosures that were:

- made to you or were authorized by you, or
- for purposes of payment functions or health care operations.

Requests for an accounting of disclosures must be submitted in writing to the Privacy Officer at the above address. Your request should specify a time period within the last six years and may not include dates before April 14, 2003. The Trust will provide one free list per twelve-month period, but the Trust may charge you for additional lists.

Right to Receive Notice: If your "Unsecured" PHI is accessed, acquired, used or disclosed in a manner that is impermissible under the HIPAA privacy rules and that poses a significant risk of financial, reputational or other harm to you, the Plan must notify you within 60 days of discovery of such "Breach" (as such terms are defined in the HIPAA privacy rules).

Right to Paper Copy: You have a right to receive a paper copy of the Trust's privacy policy and procedures at any time. To obtain a paper copy, send your written request to the Privacy Officer at the above address.

Complaints: If you believe that your privacy rights have been violated by the Trust, or by anyone acting on behalf of the Trust, you may file a complaint. Complaints to the Trust must be submitted in writing to the Privacy Officer at the above address. You may also file a complaint with the Secretary of the Department of Health and Human Services at:

Region IX, Office for Civil Rights
U.S. Department of Health and Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103
Phone: (415) 437-8310 * FAX: (415) 437-8329 * TDD: (415) 437-8311
http://www.hhs.gov/ocr/privacy/hipaa/complaints/index.html

The Trust will not retaliate against you in any way for filing a complaint.

Questions: If you have questions or want more information about any part of the Trust's privacy policy and procedures, please contact the Privacy Officer at the above address.

California's Mental Health Law

The Trust's Mental Health provider, Managed Health Network (MHN), covers two different categories of mental health care at different levels: Crisis intervention and serious mental disorders. Crisis intervention is short-term, medically necessary acute treatment for a medical condition you are unable to recover from without assistance. To receive benefits, there must be a good chance you will get better. Care is provided at the lowest level of care that is consistent with safe medical practice.

California law also requires medical benefit programs to cover the diagnosis and treatments of the following serious mental illnesses and emotional disturbances at the same rates they cover other health care: schizophrenia, schizo-affective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, pervasive developmental disorders (autism), anorexia nervosa, bulimia nervosa. Serious mental disorders also include serious emotional disturbances of a child, as indicated by the presence of one or more mental disorders from the Diagnostic and Statistical Manual (DMS) of Mental Health (other than chemical dependency or developmental disorders) as a result of the mental disorder, the child must behave inappropriately for his or her age and must also meet one of the following criteria:

- The child has a substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community and is at risk of being

removed from the home or has already been removed, or the mental disorder has been present for more than six months and is likely to continue for more than one year without treatment.

- The child is psychotic, suicidal or potentially violent.
- The child meets the special education eligibility requirements under California law.

The medical benefit program will pay for medically necessary services. If you need more information about covered services, call your HMO.

Right to Review Whether a Treatment is Experimental or Investigational for HMO Plans

If coverage for a proposed treatment is denied because it is considered experimental or investigational, you may ask that the denial be reviewed by an external independent review organization that has a contract with the California Department of Managed Health Care. To request the review, contact your HMO.

CLAIMS AND APPEALS PROCEDURES

No Employee, Dependent or other beneficiary shall have any right or claim to benefits under the Trust, except as specified in this Summary Plan Description or Trust Agreement. Any dispute as to eligibility type, amount or duration of benefit under the Trust, or any amendment or modification thereof shall be resolved by the Board of Trustees and/or the designated carrier under and pursuant to the Trust and the Trust Agreement, and its decision of the dispute shall be final and binding upon parties to the dispute.

The Trustees have complete and sole discretion to interpret the Trust documents and to determine eligibility. The Trustees have the discretionary authority and power to make factual findings, to fix omissions, to resolve plan ambiguities, to construe and interpret the terms of this plan of benefits, to make benefit eligibility determinations, to adjudicate all appeals, and to resolve other disputes under the Plan. The decisions of the Board of Trustees shall be final and binding upon all parties hereto.

The Employee, Dependent or other beneficiary must follow the claims and appeal review procedures as follows: (1) has submitted a written claim for benefits, (2) has been notified that the application is denied, (3) has filed a written request for a review of the application through all levels of appeals with the Trust Administration Office or the appropriate insurance carrier, as applicable, and (4) has been notified in writing that the insurance company or Trust has confirmed the denial of the claim. If you have a claim for benefits that is denied or ignored, in whole or in part, you may file a suit in a state or federal court but only after first exhausting the claims and appeals procedures in this SPD or such procedures as set out in the Evidence of Coverage booklets provided by the carriers. You will waive your rights to file a lawsuit against the Trust, unless you do so within 24 months after you complete the appeals process and the Fund denies your claim.

If you have a claim for a benefit, you must follow the claims appeal and review procedure set forth in the Evidence of Coverage booklet provided by PacifiCare, Dental Health Services, Davis Vision Plan, MHN and Aetna Life Insurance Company, as applicable. For details about each Provider's claims appeal and review procedures, please refer to that organization's Evi-

dence of Coverage booklet or contact the Provider directly. You may obtain an Evidence of Coverage booklet free of charge from the Trust Administration Office.

If you have a general question as to your eligibility under the Trust, please call the Trust Administration Office.

Your Claim Regarding Eligibility must be approved or denied by the Trust Administration Office within 90 days of receipt of such claim. If determination of the claim cannot be made within the time period, you will be notified prior to the end of the original 90 days and the Trust Administration Office may take up to an additional 90 days to make a decision on the claim. If your claim regarding eligibility is denied, the Trust Administration Office will notify you in writing. The notice will explain in detail the reasons for denial with specific reference to the Trust provisions upon which the denial is based, a description of any information or material necessary to perfect the claim and an explanation of the right to appeal.

Your Claims Made After Treatment under the Options Rider: - If you make a claim for benefits under the Option Riders after you receive the treatment, your claim will be decided within a reasonable time no longer than 30 days after receipt of your claim. However, an additional 15 days may be needed if there are special circumstances beyond the Plan's control. If so, you will be given notice of the special circumstances before the end of the first 30 days and told whether additional information is needed to decide your claim. You will have at least 45 days to provide the additional information.

Claim Procedures by Providers

For claims and appeals to the Provider, the Provider will promptly review your claim and appeal. It will advise you of its decision, in writing, giving the specific reasons for the decision with reference to policy provisions on which the decision is based.

If an unpaid claim has been sent directly to you, refer to the specific Provider Evidence of Coverage (EOC) for details on how to submit such claims. Claims should be filed within 90 days of the date of service, or as soon as reasonably possible. The Trust Administration Office will be happy to assist you in resolving claims issues, please contact the Trust Administration Office as soon as an issue arises.

PacFed Benefit Administrators, Inc.
1000 N. Central Ave., Suite 400
Glendale, CA 91202
(818) 243-0222 or (800) 753-0222

If you have had benefits provided and disagree with the claims payment, immediately contact the Trust Administration Office who will assist you in explaining your benefits, or may intervene on your behalf with the Provider. **However, you must contact the Trust Administration Office in writing within 12 months of the date of service, if you wish to contest the denial of the claim in whole or in part**. To file a formal appeal you must follow the Appeal Procedures in this booklet.

Appeal Procedures

If your claim for eligibility or under the Options Rider is denied, the following appeal procedures apply:

1) **To file an appeal regarding eligibility** you must file a written appeal within 60 days of notice of the claim denial of eligibility. You may submit any written records you wish to be reviewed and you may obtain copies of any related Plan records.

   Your appeal will be decided by the next regularly-scheduled meeting of the Board of Trustees that is at least 30 days after your written appeal is received. If special circumstances require additional time to process your appeal, you will be notified of those circumstances and a decision will be made no later than the third meeting following receipt of your written appeal.

   If your appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons, reference to the specific plan provisions, and you may have access to all records that were used in reaching the decision.

2) To file an appeal **under the Options Rider**, you must file a written appeal within 180 days of notice of the denial of the claim. Failure to file an appeal within the 180-day period will constitute a waiver of your right to appeal the denial or to take any other action with respect to it, although the Board of Trustees may consider an appeal submitted up to one year from the date of the denial notice provided that good cause is shown for the delay. Your appeal must state in clear and concise terms the reason or reasons for disputing the denial, and you must provide any pertinent documents not already furnished to the Trust.

   Appeals of claims made after treatment will be decided by the next regularly-scheduled meeting of the Board of Trustees that is at least 30 days after your written appeal is received. If special circumstances require additional time to process your appeal, you will be notified of those circumstances and a decision will be made no later than the third meeting following your receipt of your written appeal.

   If your appeal is denied, you will receive written (or electronic as permitted by law) notice, including the specific reasons, reference to the specific plan provisions, and you may have access to all records that were used in reaching the decision.

   If the denial is based on medical necessity or experimental treatment, or the like, you may have a copy of whatever scientific or clinical explanation was used in the determination.

If you file an appeal, you will be provided the opportunity to submit written comments, documents, records, and other information relating to your claim. You will be provided, upon request and free of charge, reasonable access to, and copies of, all documents, records, and other information relevant (that is not privileged or protected) to your claim. As part of the appeal process, the Trust Administration Office will take into account all comments, documents, records and other information submitted by you relating to the claim, without regard to whether such information was submitted or considered in the initial benefit determination.

The review on appeal will not afford deference to the initial determination and will be conducted by an appropriate named fiduciary who is neither the individual who made the initial benefit determi-

nation that is the subject of the appeal, nor the subordinate of that individual. In deciding an appeal of a benefit determination that is based in whole or in part on a medical judgment, including determinations with regard to whether a particular treatment, drug, or other item is experimental, investigational, or not medically necessary or appropriate, the appropriate named fiduciary will consult with a health care professional who has appropriate training and experience in the field of medicine involved in the medical judgment and that individual will not be the person who was consulted in connection with the initial determination (or his/her subordinate). Upon request, you will be provided with the identification of the medical experts whose advice was obtained on behalf of the plan in connection with the adverse determination, without regard to whether the advice was relied upon in making the determination.

The decision of the Board of Trustees, with respect to a request for reconsideration, shall be final and binding upon all parties, including the claimant and any person claiming through the claimant. The Trustees' decisions are subject to judicial review only for abuse of discretion.

If you are not satisfied with the decision made on your appeal, you may file a lawsuit in federal court against the Plan. However, you must complete the appeal to the Trustees before you may file a lawsuit. You will waive your rights to file a lawsuit against the Trust, unless you do so within 24 months after you complete the appeals process and the Fund denies your Claim

INFORMATION REQUIRED BY THE EMPLOYEE RETIREMENT INCOME SECURITY ACT (ERISA) OF 1974

TRUST SPONSOR:

Multi Union Security Trust Fund

NAME AND ADDRESS OF TRUST ADMINISTRATOR:

Multi Union Security Trust Fund
c/o PacFed Benefit Administrators, Inc.
1000 North Central Ave., Suite 400
Glendale, CA 91202
(818) 243-0222

TYPE OF ADMINISTRATION:

The Trust is administered by the Board of Trustees, which, in turn, have engaged the third party administrative services of PacFed Benefit Administrators, Inc.

Most of the benefits are provided through group insurance policies and pre-paid service plans, or organizations, which have agreements with the Trust. The benefits provided through these policies and agreements are governed by the terms of those contracts. Copies of these documents are available for inspection at the Trust Administration Office. Payments by the Trust are subject to the terms of the Collective Bargaining Agreement and to the availability of funds to the Trust.

NAME AND ADDRESS OF AGENT FOR SERVICE OF LEGAL PROCESS:

The following third Party Administrator has been designated by the Trustees as the agent for service of legal process.

Mr. Michael L. Cox
PacFed Benefit Administrators, Inc.
1000 North Central Ave., Suite 400
Glendale, CA 91202

Service may also be made on any Trustee.

INTERNAL REVENUE SERVICE PLAN IDENTIFICATION NUMBER: 93-1146155

PLAN NUMBER: 501

PLAN FISCAL YEAR ENDS: December 31

APPLICABLE COLLECTIVE BARGAINING AGREEMENTS:

The Trust is maintained in accordance with Collective Bargaining Agreements between various Employers and Union Locals and District Councils. The Collective Bargaining Agreements require contributions from the participating Employers to provide the benefits described in this booklet. Copies of the Collective Bargaining Agreements are available for inspection at the Trust Administration Office during regular business hours, and upon written request, will be furnished by mail. You will be charged for the cost of being furnished such a copy. You may also request information as to whether a particular Employer is a sponsor of the Multi Union Security Trust Fund.

SOURCE OF FINANCING OF THE PLAN:

All contributions to the Trust are made by individual Employers in compliance with Collective Bargaining Agreements in force with one of its affiliated Local Unions or a recognized Subscription Agreement.

The benefits provided by this Trust, while intended to remain in effect indefinitely, can be guaranteed only as long as the parties to the Collective Bargaining Agreements continue to require contributions to the Trust sufficient to underwrite the cost of the benefits. Should contributions cease and the reserves expended, the Trustees would no longer be obligated to furnish coverage. These are not guaranteed lifetime benefits.

TRUST TERMINATION:

The Board of Trustees may terminate the Trust pursuant to its authority under the Trust Agreement. In no event will the termination of the Trust result in a reversion of any assets to a participating Employer.

NAMES AND ADDRESSES OF TRUSTEES:

Trustees:	Address:
R.M. “Spike” Irwin Jennifer L. Young Mike Bergen Jason Hodge Sean Harren	c/o PacFed Benefit Administrators, Inc. 1000 North Central Ave., Suite 400 Glendale, CA 91202

INSURERS AND PROVIDERS OF SERVICE TO THE TRUST:

The carriers and providers of service to the Trust are as follows:

For Life and Accidental Death and Dismemberment Benefits

Aetna Life Insurance Company
151 Farmington Avenue
Hartford, CT 06156

For Hospital, Medical, Surgical and Prescription Drug Benefits

PacifiCare of California
P.O. Box 30968
Salt Lake City, UT 84130-0968

For Dental Benefits

Dental Health Services
3833 Atlantic Ave.
Long Beach, CA 90807-3505

For Vision Benefits

Davis Vision Plan
159 Express Street
Plainview, NY 11803

For Mental Health Program Benefits

Managed Health Network, Inc. (MHN)
2370 Kerner Blvd
San Rafael, CA 94901

STATEMENT OF ERISA RIGHTS

As a participant covered under this Trust, you are entitled to certain rights and protections under the Employee Retirement Income Security Act of 1974 (ERISA). ERISA provides that all Trust participants shall be entitled to:

Receive Information About Your Plan and Benefits

- Examine, without charge, at the Trust Administration Office and at Union Local offices all Trust documents, including insurance contracts and collective bargaining agreements, and a copy of the latest annual report (Form 5500 Series) filed by the Trust 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 Trust Administration Office, copies of documents governing the operation of the Trust, including insurance contracts and collective bargaining agreement, and copies of the latest annual report (Form 5500 Series) and updated summary plan description. The Trust Administration Office may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Trust Administration Office is required by law to furnish each participant with a copy of this summary financial report.

Continue Group Health Plan Coverage

Continue health coverage for yourself, spouse or dependents if there is a loss of coverage under the Plan as a result of a Qualifying Event. You or your dependents may have to pay for such coverage. Review this summary plan description and the documents governing the Plan on the rules governing COBRA continuation coverage rights.

You can reduce or eliminate exclusionary periods of coverage for preexisting conditions under your group health plan, if you have creditable coverage from another plan. 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 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. Without evidence of creditable coverage, you may be subject to a preexisting condition exclusion for 12 months (18 months for late enrollees) after your enrollment date in your coverage.

Prudent Actions by Fiduciaries

In addition to creating rights for Trust participants, ERISA imposes obligations upon the persons who are responsible for the operation of the Trust's benefits. The people who operate your Plan, called "fiduciaries" of the Plan, have a duty to do so prudently and in the interest of you and other Plan participants and beneficiaries. No one, including your Employer, your Union, or any other person, may fire you or otherwise discriminate against you in a 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 Trust documents or the latest annual report from the Trust 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 Trust Administration Office 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 Trust Administration Office. If you have a claim for benefits which is denied or ignored, in whole or in part, you may file suit in a State or Federal court but only after first exhausting the claims and appeals procedures under this Trust or with the designated carrier, if applicable. In addition, if you disagree with the Trust's decision or lack thereof concerning the qualified status of a medical child support order, you may file suit in Federal court but only after first exhausting the claims and appeals procedures under this Trust. If it should happen that Trust fiduciaries misuse the Trust's money, or if you are discriminated against for asserting your rights, you may seek assistance from the U.S. Department of Labor, or you may file suit in a Federal court. The court will decide who should pay court costs and legal fees. If you are successful, the court may order the person you have sued to pay these costs and fees. If you lose, the court may order you to pay these costs and fees, for example, if it finds your claim is frivolous.

Assistance with Your Questions

If you have any questions about the Trust or your benefits, you should contact the Trust Administration Office. If you have questions about this statement or about your rights under ERISA, or if you need assistance in obtaining documents from the Trust Administration Office, you should contact the nearest office of the Employee Benefits Security Administration, U.S. Department of Labor, listed in your telephone directory or the Division of Technical Assistance and Inquiries, Employee Benefits Security Administration, U.S. Department of Labor, 200 Constitution Avenue N.W., Washington, D.C. 20210. You may also obtain certain publications about your rights and responsibilities under ERISA by calling the publications hotline of the Employee Benefits Security Administration.

DEPARTMENT OF MANAGED HEALTH CARE

The California Department of Managed Health Care is responsible for regulating health care service plans. The Department has a toll-free number to receive complaints: (800) 400-0815. If a member has a grievance against one of the health care providers offered by this Trust, the member should contact that organization and use its grievance process as outlined in its Evidence of Coverage booklet. If a Member requires help with a complaint involving an emergency or with a grievance that has not been satisfactorily resolved by the health care provider, you may call the Department's toll-free telephone number.

MULTI UNION SECURITY TRUST FUND

SCHEDULES OF BENEFITS

ADDENDUM

MULTI UNION SECURITY TRUST FUND
OPTIONS RIDER

Introduction

Multi Union Security Trust Fund is making health coverage easier than ever. The Multi Union Security Trust Fund OPTIONS Rider is designed to give you increased flexibility in your selection of outpatient services. This plan is specifically designed to complement your HMO coverage. It provides you and your covered family members the opportunity to receive selected outpatient services from any physician. It also covers some services that are not normally covered under your HMO benefit plan. The OPTIONS Rider is not meant to replace your HMO coverage and those services provided through your Primary Care Physician and selected hospital.

Benefits are limited to outpatient services such as physician office visits. Specifically excluded are inpatient services, major surgical procedures and maternity care in any setting. The Benefit Summary on the next page provides details about your coverage. You will note that there is a calendar year deductible and a benefit maximum for each covered family member. **All claims and required supporting documentation must be submitted within 15 months of the date of service. Claims and documentation submitted after such time period will not be considered.**

Here's How It Works

From time to time you may wish to obtain services for yourself or a covered family member from:

- physicians or other providers who are not participants in the HMO network.
- specialist physicians or other providers whom you wish to see without a referral.
- primary care physicians other than your own primary care physician.

You may also wish to obtain services that are not covered under your HMO benefit plan. The OPTIONS Rider provides you with this flexibility subject to the coverage described in the Disclosure Statement and Benefit Summary.

After you have received and paid for covered services, complete a claim form and provide your proof of payment to us. We consider any of the following to be proof of payment.

- canceled checks (photocopies of both sides);
- itemized medical bills indicating the amounts paid;
- patient account ledger(s) with your payment noted; and/or
- receipts in addition to itemized medical bills.

At the time of enrollment you will be provided with the necessary claim forms. If you have any questions regarding the claim form, proof of payment, or the need for additional claim forms, please call PacFed Benefit Administrators, Inc. at (818) 243-0222.

Options Rider Benefit Summary

Calendar Year Maximum $ 5,000

Individual Deductible $ 100 (Each covered individual must satisfy this deductible).

The Options Rider includes coverage for physician and outpatient services, and specialized footwear that are Medically Necessary as outlined below. Inpatient services, major surgery and maternity care are expressly excluded. This Rider is offered only in conjunction with an HMO benefit plan.

For this Options Rider only, "Medically Necessary" means an intervention is *medically necessary* if, as recommended by the treating physician and determined by the health plan's medical director, it is (all of the following): A health intervention for the purpose of treating a medical condition; the most appropriate supply or level of service, considering potential benefits and harms to the patient; known to be effective in improving health outcomes. For new interventions, effectiveness is determined by scientific evidence. For existing interventions, effectiveness is determined first by scientific evidence, then by professional standards, then by expert opinion; and cost effective for this condition compared to alternative interventions including no intervention. "Cost effective" does not necessarily mean the lowest price.

Should claims that are "Medically Necessary" appear to be ambiguous or in dispute, the Trustees grant the Administrative Office the discretion to determine what is "Medically Necessary" for initial claims only. The Trustees retain this discretion with respect to all claims (other than the initial claims).

Covered Expenses	**Benefit Reimbursement**
Physician Services	
• Outpatient services, including: • Office Visits • Preventive care for children • Minor Surgical Procedures (As defined in #6 of the Limitations & Exclusions section.) • Radiology • Pathology	80% of charges not to exceed customary and reasonable amount

Mental or Nervous Disorders and Alcohol and Chemical Dependency

- Outpatient services, including: 50% of charges not to exceed customary & reasonable amount
- Psychotherapy & counseling
- Treatment of alcoholism & chemical dependency

Additional Services

- Outpatient diagnostic laboratory and x-ray 80% of charges not to exceed customary and reasonable amount
- Chiropractic and Podiatric Services
- Specialized Footwear

Specialized footwear, including foot orthotics, such as custom-made orthopedic shoes or custom molded orthotics, deemed to be Medically Necessary by a certified orthotist, certified prosthetist, or Medical Doctor for You and your Dependents.

You and Your Dependents will not receive this benefit if you have diabetic foot disease and are covered by the plan of benefits provided by PacifiCare/UHC.

The Plan will pay a maximum of $500 per calendar year or as otherwise authorized by the Trustees towards the cost of the specialized footwear referred to above when they are considered to be Medically Necessary.

When filing a claim for such specialized footwear, you must submit the original bill, indicating that the specialized footwear is Medically Necessary, and the notice from PacifiCare/UHC, declining coverage under its plan of benefits.

Limitations and Exclusions

The following are **not covered expenses** of the OPTIONS Rider:

1. Charges that are not included in "Covered Expenses".
2. Charges for medical services or specialized footwear that are not Medically Necessary.
3. Charges for copayments, deductibles and/or coinsurance paid under your HMO benefit plan.
4. Charges for inpatient hospital services and for any other type of facility charges. Emergency room charges are not covered.
5. Charges for maternity care in any setting.
6. Charges for surgical procedures other than Minor Surgical Procedures. We consider Minor Surgical Procedures to be ones that:
    - can be performed in a physician's office;

- do not require the services of an anesthesiologist or anesthetist;
- do not involve the use of an operating room or specialized surgical suite;
- do not result in professional charges in excess of $500 per procedure.

7. Charges for adult physical examinations.
8. Charges due to cosmetic, plastic or reconstructive surgery unless these conditions are met:
   a) the surgery must be required to remedy a condition that results from an injury or from a mastectomy or to correct a functional disorder as a result of a congenital defect; and,
   b) the surgery meets the criteria in number 6, above.
   Please note: We consider Rhinoplasty and Septoplasty to be cosmetic surgery, unless performed as a result of an injury.
9. Charges for:
   a) any of the following items including their prescription or fitting:
      i. hearing aids;
      ii. optical or visual aids, including contact lenses and eyeglasses;
      iii. wigs and hair transplants; and
      iv. disposable supplies for use by covered persons
   b) any examination to determine the need for or the proper adjustments of any item listed above.
   c) any procedure to correct refractive error.
   d) radial keratotomy.
10. Charges for items generally used for personal comfort and/or useful to the Covered Person's household, including but not limited to:
    a) all types of beds;
    b) air conditioners, humidifiers, air cleaners, filtration units and related apparatus;
    c) whirlpools, saunas and related apparatus;
    d) medical equipment generally used only by physicians in their work;
    e) vans and van lifts;
    f) stair lifts; and,
    g) exercise bicycles and other types of exercise equipment.
11. Charges for care, treatment, services or supplies that are primarily for dietary control, including but not limited to any exercise programs:
    a) whether formal or informal, and
    b) whether or not recommended by a physician
12. Charges for dental work.

13. Charges for treatment of Temporomandibular Joint Syndrome ('TMJ").
14. Charges for testing, training, or rehabilitation for educational, developmental or vocational purposes.
15. Charges for treatment of a learning disability.
16. Charges made by a physician, surgeon, nurse or other practitioner who:
    a) normally lives with a Covered Person; or,
    b) is a member of the Covered Person's family.
17. Charges incurred for home health care or hospice care.
18. Charges incurred for care or treatment of an intentionally self-inflicted injury, while sane or insane.
19. Charges incurred for treatment with fertility drugs or artificial insemination and in-vitro fertilization including development and implantation of an embryo developed in-vitro).

20. Charges for telephone consultations.
21. Charges for acupuncture.
22. Charges incurred by a Covered Person after he or she is no longer insured under the policy or by any coverage continued under the "Extended Benefit Provisions" or the policy.
23. Charges for which a Covered Person is entitled to payment under any local, state or federal Governmental agency including Medicare, but not MediCal.
24. Charges made by a hospital owned or run by the United State Government, with the exception of Veterans Administration Hospitals for non-service related charges.
25. Charges that in the absence of insurance would not be made; or charges for which there is no legal obligation to pay.
26. Charges for treatment:
    a) of an injury resulting from or due to any employment for wage or profit, unless the Covered Person does not qualify for coverage under any Workers' Compensation or similar laws; or
    b) sickness that is covered under any Workers' Compensation or similar laws.
27. Charges for injury or sickness resulting from any act of war, even if war has not been declared.
28. Charges resulting from non-therapeutic release of nuclear energy.
29. Charges for:
    - dress shoes and casual shoes, e.g. tennis shoes.
    - foot pads that are not custom-made;
    - foot orthotics that are not custom-made;
    - foot orthotics that are soft molded or made from cork and leather; and
    - socks or any supplies that are not custom made or of which its equivalent can be purchased without prescription as a standard shelf item.

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Offered by PacifiCare of California

10/100%

HMO Schedule of Benefits

Effective 2-1-2011

These services are covered as indicated when authorized through your Primary Care Physician in your Participating Medical Group.

General Features

Calendar Year Deductible	0
Maximum Benefits	Unlimited
Annual Copayment Maximum[1] (3 individual maximum per family)	$2,000/individual
Office Visits	$10 Copayment
Hospital Benefits	Paid in full
Emergency Services (Copayment waived if admitted)	$50 Copayment
Urgently Needed Services (Medically Necessary services required outside geographic area served by your Participating Medical Group. Please consult your brochure for additional details. Copayment waived if admitted)	$50 Copayment
Pre-Existing Conditions	All conditions covered, provided they are covered benefits

Benefits Available While Hospitalized as an Inpatient

Bone Marrow Transplants	Paid in full
Cancer Clinical Trials[2]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Hospital Benefits[3]	Paid in full
Mastectomy/Breast Reconstruction (After mastectomy and complications from mastectomy)	Paid in full
Maternity Care	Paid in full
Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.**)	Paid in full
Newborn Care[3]	Paid in full
Physician Care	Paid in full
Reconstructive Surgery	Paid in full
Rehabilitation Care (Including physical, occupational and speech therapy)	Paid in full
Skilled Nursing Facility Care (Up to 100 consecutive calendar days from the first treatment per disability)	Paid in full

Benefits Available While Hospitalized as an Inpatient (Continued)

Voluntary Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 $125 Copayment $125 Copayment

Benefits Available on an Outpatient Basis

Allergy Testing/Treatment (Serum is covered)	$10 Office Visit Copayment
Ambulance	Paid in full
Cancer Clinical Trials[2]	Paid at negotiated rate Balance (if any) is the responsibility of the Member
Cochlear Implant Devices (Additional Copayment for outpatient surgery or inpatient hospital benefits and outpatient rehabilitation therapy may apply)	Paid in full
Dental Treatment Anesthesia (Additional Copayment for outpatient surgery or inpatient hospital benefits may apply)	$10 Office Visit Copayment
Dialysis (Physician office visit Copayment may apply)	$10 Copayment per treatment
Durable Medical Equipment ($5,000 annual benefit maximum per calendar year)	Paid in full
Durable Medical Equipment for the Treatment of Pediatric Asthma (Includes nebulizers, peak flow meters, face masks and tubing for the Medically Necessary treatment of pediatric asthma of Dependent children under the age of 19. Does not apply to the annual Durable Medical Equipment benefit maximum.)	Paid in full
Family Planning/Voluntary Termination of Pregnancy Vasectomy Tubal Ligation (Additional Copayment for inpatient hospital benefits may apply if performed on an inpatient basis.) Insertion/Removal of Intra-Uterine Device (IUD) Intra-Uterine Device (IUD) Removal of Norplant Depo-Provera Injection Depo-Provera Medication (Limited to one Depo-Provera injection every 90 days) Voluntary Termination of Pregnancy (Medical/medication and surgical) 1st trimester 2nd trimester (12-20 weeks) – After 20 weeks, not covered unless Medically Necessary, such as the mother's life is in jeopardy or fetus is not viable.	 $50 Copayment $100 Copayment $10 Office Visit Copayment $50 Copayment $10 Office Visit Copayment $10 Office Visit Copayment $35 Copayment $125 Copayment $125 Copayment
Health Education Services	Paid in full
Hearing Aid – Standard ($5,000 Benefit Maximum every three years. Limited to a single hearing aid (including repair/replacement) every three years)	Paid in full
Hearing Aid – Bone Anchored[5] (Limited to a single hearing aid during the entire period of time the member is enrolled in the Health Plan (per lifetime). Repairs and/or replacements are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.)	Depending upon where the covered health service is provided, benefits for bone anchored hearing aid will be the same as those stated under each covered health service category in this Schedule of Benefits

Benefits Available on an Outpatient Basis (Continued)

Hearing Screening	$10 Office Visit Copayment
Home Health Care Visits (Up to 100 visits per calendar year)	Paid in full
Hospice Services (Prognosis of life expectancy of one year or less)	Paid in full
Immunizations (For children under two years of age, refer to Well-Baby Care)	Paid in full
Infertility Services	Not covered
Infusion Therapy (Infusion Therapy is a separate Copayment in addition to a home health care or an office visit Copayment. Copayment applies per 30 days or treatment plan, whichever is shorter)	Paid in full
Injectable Drugs (Outpatient Injectable Medications and Self-Injectable Medications) (Copayment not applicable to allergy serum, immunizations, birth control, Infertility and insulin. The Self-Injectable medications Copayment applies per 30 days or treatment plan, whichever is shorter. Please see the PacifiCare Combined Evidence of Coverage and Disclosure Form for more information on these benefits, if any. Office visit Copayment may also apply)	$50 Copayment per visit[4]
Laboratory Services (When available through or authorized by your Participating Medical Group)	Paid in full
Maternity Care, Tests and Procedures	Paid in full
Mental Health Services (As required by state law, coverage includes treatment for Severe Mental Illness (SMI) of adults and children and the treatment of Serious Emotional Disturbance of Children (SED). **Please refer to your Supplement to the PacifiCare Combined Evidence of Coverage and Disclosure Form for a description of this coverage.**)	$10 Office Visit Copayment
Oral Surgery Services	Paid in full
Outpatient Medical Rehabilitation Therapy at a Participating Free-Standing or Outpatient Facility (Including physical, occupational and speech therapy)	$10 Office Visit Copayment
Outpatient Surgery at a Participating Free-Standing or Outpatient Surgery Facility	Paid in full
Periodic Health Evaluations (Physician, laboratory, radiology and related services as recommended by the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group to determine your health status. For children under two years of age, refer to Well-Baby Care)	Paid in full
Physician Care (For children under two years of age, refer to Well-Baby Care)	$10 Office Visit Copayment
Prosthetics and Corrective Appliances	Paid in full

Benefits Available on an Outpatient Basis (Continued)

Radiation Therapy Standard: (Photon beam radiation therapy) Complex: (Examples include, but are not limited to, brachytherapy, radioactive implants and conformal photon beam; Copayment applies per 30 days or treatment plan, whichever is shorter; GammaKnife and stereotactic procedures are covered as outpatient surgery. Please refer to outpatient surgery for Copayment amount if any)	Paid in full Paid in full
Radiology Services Standard: Specialized scanning and imaging procedures: (Examples include but are not limited to, CT, SPECT, PET, MRA and MRI – with or without contrast media)	Paid in full Paid in full
Vision/Refractions	$10 Office Visit Copayment
Well-Baby Care (Preventive health service, including immunizations as recommended by the American Academy of Pediatrics (AAP), Advisory Committee on Immunization Practices (ACIP) and U.S. Preventive Services Task Force and authorized through your Primary Care Physician in your Participating Medical Group for children under two years of age. The applicable office visit Copayment applies to infants that are ill at time of services)	Paid in full
Well-Woman Care (Includes Pap smear (by your Primary Care Physician or an OB/GYN in your Participating Medical Group) and referral by the Participating Medical Group for screening mammography as recommended by the U.S. Preventive Services Task Force)	Paid in full

[1] Annual Copayment Maximum does not include Copayments for pharmacy and supplemental benefits, except Behavioral Health Supplemental Benefits.

[2] Cancer Clinical Trial services require preauthorization by PacifiCare. If you participate in a Cancer Clinical Trial provided by a Non-Participating Provider that does not agree to perform these services at the rate PacifiCare negotiates with Participating Providers, you will be responsible for payment of the difference between the Non-Participating Providers billed charges and the rate negotiated by PacifiCare with Participating Providers, in addition to any applicable Copayments, coinsurance or deductibles.

[3] The inpatient hospital benefits Copayment does not apply to newborns when the newborn is discharged with the mother within 48 hours of the normal vaginal delivery or 96 hours of the cesarean delivery. Please see the Combined Evidence of Coverage and Disclosure Form for more details.

[4] In instances where the negotiated rate is less than your Copayment, you will pay only the negotiated rate.

[5] Bone anchored hearing aid will be subject to applicable medical/surgical categories (e.g. inpatient hospital, physician fees) only for members who meet the medical criteria specified in the Combined Evidence of Coverage and Disclosure Form. Limited to one (1) bone anchored hearing aid during the period of time the member is enrolled in the Health Plan (per lifetime). Repairs and/or replacement for a bone anchored hearing aid are not covered, except for malfunctions. Deluxe model and upgrades that are not medically necessary are not covered.

Except in the case of a Medically Necessary Emergency or an Urgently Needed Service (outside geographic area served by your Participating Medical Group), each of the above-noted benefits is covered when authorized by your Participating Medical Group or PacifiCare. A Utilization Review Committee may review the request for services.

Note: This is not a contract. This is a Schedule of Benefits and its enclosures constitute only a summary of the Health Plan.

The Medical and Hospital Group Subscriber Agreement and the PacifiCare of California Combined Evidence of Coverage and Disclosure Form and additional benefit materials must be consulted to determine the exact terms and conditions of coverage. A specimen copy of the contract will be furnished upon request and is available at the PacifiCare office and your employer's personnel office. PacifiCare's most recent audited financial information is also available upon request.

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HMO Pharmacy Schedule of Benefits

Summary of Benefits	Generic Formulary	Brand-name Formulary	Non-Formulary
Retail Pharmacy Copayment (per Prescription Unit or up to 30 days)	$5	$10	$25
Mail Service Pharmacy Copayment (three Prescription Units or up to a 90-day supply)	$10	$20	$50

This *Schedule of Benefits* provides specific details about your prescription drug benefit, as well as the exclusions and limitations. Together, this document and the *Supplement to the Combined Evidence of Coverage and Disclosure Form* as well as the medical *Combined Evidence of Coverage and Disclosure Form* determine the exact terms and conditions of your prescription drug coverage.

What do I pay when I fill a prescription?

You will pay only a Copayment when filling a prescription at a PacifiCare Participating Pharmacy. You will pay a Copayment every time a prescription is filled. Your Copayments are as shown in the grid above.

There are selected brand-name medications where you will pay a generic Copayment of just $5. A copy of the Selected Brands List is available upon request from PacifiCare's Customer Service department and may be found on PacifiCare's Web site at **www.pacificare.com**.

Preauthorization

Selected generic Formulary, brand-name Formulary and non-Formulary medications require a Member to go through a Preauthorization process using criteria based upon Food and Drug Administration (FDA)-approved indications or medical findings, and the current availability of the medication. PacifiCare reviews requests for these selected medications to ensure that they are Medically Necessary, being prescribed according to treatment guidelines consistent with standard professional practice and are not otherwise excluded from coverage.

Because PacifiCare offers a comprehensive Formulary, selected non-Formulary medications will not be covered until one or more Formulary alternatives, or non-Formulary preferred drugs have been tried. PacifiCare understands that situations arise when it may be Medically Necessary for you to receive a certain medication without trying an alternative drug first. In these instances, your Participating Physicians will need to provide evidence to PacifiCare in the form of documents, lab results, records or clinical trials that establish the use of the requested medications as Medically Necessary. Participating Physicians may call or fax Preauthorization requests to PacifiCare. Applicable Copayments will be charged for prescriptions that require Preauthorization if approved.

For a list of the selected medications that require PacifiCare's Preauthorization, please contact PacifiCare's Customer Service department.

Medication Covered by Your Benefit

When prescribed by your Participating Physician as Medically Necessary and filled at a Participating Pharmacy, subject to all the other terms and conditions of this outpatient prescription drug benefit, the following medications are covered:

- **Disposable all-in-one prefilled insulin pens**, insulin cartridges and needles for nondisposable pen devices are covered when Medically Necessary, in accordance with PacifiCare's Preauthorization process.
- **Federal Legend Drugs**: Any medicinal substance which bears the legend: "Caution: Federal law prohibits dispensing without a prescription."
- **Generic Drugs**: Comparable generic drugs may be substituted for brand-name drugs unless they are on PacifiCare's Selected Brands List. A copy of the Selected Brands List is available upon request from PacifiCare's Customer Service department or may be found on PacifiCare's Web site at **www.pacificare.com**.
- **Miscellaneous Prescription Drug Coverage**: For the purposes of determining coverage, the following items are considered prescription drug benefits and are covered when Medically Necessary: glucagons, insulin, insulin syringes, blood glucose test strips, lancets, inhaler extender devices, urine test strips and anaphylaxis prevention kits (including, but not limited to, EpiPen®, Ana-Kits® and Ana-Guard®). See the medical *Combined Evidence of Coverage and Disclosure Form* for coverage of other injectable medications in Section Five under "Your Medical Benefits."

Questions? Call the Customer Service Department at 1-800-624-8822.

Custodial Care in any facility, relatives, friends or caregivers may purchase the medication prescribed by a Participating Physician at a Participating Pharmacy and pay the applicable Copayment on behalf of the Member.

- **Investigational or Experimental Drugs:** Medication prescribed for experimental or investigational therapies are not covered, unless required by an external, independent review panel pursuant to California Health and Safety Code Section 1370.4. Further information about Investigational and Experimental procedures and external review by an independent panel can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, "Your Medical Benefits" and Section Eight, "Overseeing Your Health Care" for appeal rights.
- **Medications dispensed by a non-Participating Pharmacy** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **Medications prescribed by non-Participating Physicians** are not covered except for prescriptions required as a result of an Emergency or Urgently Needed Service.
- **New medications that have not been reviewed for safety, efficacy and cost-effectiveness and approved** by PacifiCare are not covered unless Preauthorized by PacifiCare as Medically Necessary.
- **Non-Covered Medical Condition:** Prescription medications for the treatment of a non-covered medical condition are not covered. This exclusion does not exclude Medically Necessary medications directly related to non-Covered Services when complications exceed follow-up care, such as life-threatening complications of cosmetic surgery.
- **Off-Label Drug Use.** Off-Label Drug Use means that the Provider has prescribed a drug approved by the Food and Drug Administration (FDA) for a use that is different than that for which the FDA approved the drug. PacifiCare excludes coverage for Off-Label Drug Use, including off-label, self-injectable drugs, except as described in the medical *Combined Evidence of Coverage and Disclosure Form* and any applicable Attachments. If a drug is prescribed for Off-Label Drug Use, the drug and its administration will be covered only if it satisfies the following criteria: (1) The drug is approved by the FDA. (2) The drug is prescribed by a participating licensed health care professional. (3) The drug is Medically Necessary to treat the medical condition. (4) The drug has been recognized for treatment of a medical condition by one of the following: *The American Hospital Formulary Service Drug Information, The United States Pharmacopeia Dispensing Information* or in two articles from major peer-reviewed medical journals that present data supporting the proposed Off-Label Drug Use or uses as generally safe and effective. Nothing in this section shall prohibit PacifiCare from use of a Formulary, Copayment, technology assessment panel, or similar mechanism as a means for appropriately controlling the utilization of a drug that is prescribed for a use that is different from the use for which that drug has been approved for marketing by the FDA. Denial of a drug as Investigational or Experimental will allow the Member to use the Independent Medical Review System as defined in the medical *Combined Evidence of Coverage and Disclosure Form.*
- **Over-the-Counter Drugs:** Medications (except insulin) available without a prescription (over-the-counter) or for which there is a nonprescription chemical and dosage equivalent available, even if ordered by a Physician, are not covered. All nonprescription (over-the-counter) contraceptive jellies, ointments, foams or devices are not covered.
- **Prior to Effective Date:** Drugs or medicines purchased and received prior to the Member's effective Date or subsequent to the Member's termination are not covered.
- **Replacement** of lost, stolen or destroyed medications are not covered.
- **Saline and irrigation solutions** are not covered. Saline and irrigation solutions are covered when Medically Necessary, depending on the purpose for which they are prescribed, as part of the home health or Durable Medical Equipment benefit. Refer to your medical *Combined Evidence of Coverage and Disclosure Form* Section Five for additional information.
- **Sexual Dysfunction Medication:** All forms of medications when prescribed for the treatment of sexual dysfunction, which includes, but is not limited to, erectile dysfunction, impotence, anorgasmy or hyporgasmy, are not covered. An example of such medications includes Viagra.
- **Smoking cessation products,** including, but not limited to, nicotine gum, nicotine patches and nicotine nasal spray, are not covered. However, smoking cessation products are covered when the Member is enrolled in a smoking cessation program approved by PacifiCare. For information on PacifiCare's smoking cessation program, refer to the medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, "Your Medical Benefits, in the section titled "Outpatient Benefits", under "Health Education Services" or contact Customer Service or visit our Web site at **www.pacificare.com**.

- **Therapeutic devices** or **appliances,** including, but not limited to, support garments and other nonmedical substances, insulin pumps and related supplies (these services are provided as Durable Medical Equipment) and hypodermic needles and syringes not related to diabetic needs or cartridges are not covered. Birth control devices and supplies or preparations that do not require a Participating Physician's prescription by law are also not covered, even if prescribed by a Participating Physician. For further information on certain therapeutic devices and appliances that are covered under your medical benefit, refer to your medical *Combined Evidence of Coverage and Disclosure Form* in Section Five, titled "Your Medical Benefits" under "Outpatient Benefits" located, for example, in subsections titled "Diabetic Self Management", "Durable Medical Equipment," or "Home Health Care and Prosthetics and Corrective Appliances."
- **Workers' Compensation**: Medication for which the cost is recoverable under any workers' compensation or occupational disease law or any state or government agency, or medication furnished by any other drug or medical service for which no charge is made to the patient is not covered. Further information about workers' compensation can be found in the medical *Combined Evidence of Coverage and Disclosure Form* in Section Six under "Payment Responsibility."

PacifiCare reserves the right to expand the Preauthorization requirement for any drug product.

Questions? Call the HMO Customer Service department at 1-800-624-8822 or TDHI 1-800-442-8833.

P.O. Box 6006
Cypress, CA 90630

Customer Service:
800-624-8822
800-442-8833 (TDHI)
www.pacificare.com

CM-404-63007
PC1585
3RE/3RF

- **Oral Contraceptives:** Federal Legend oral contraceptives, prescription diaphragms and oral medications for emergency contraception.
- **State Restricted Drugs:** Any medicinal substance that may be dispensed by prescription only, according to state law.

Exclusions and Limitations

While the prescription drug benefit covers most medications, there are some that are not covered or limited. These drugs are listed below. Some of the following excluded drugs may be covered under your medical benefit. Please refer to Section Fiveof your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for more information about medications covered by your medical benefit.

- **Administered Drugs:** Drugs or medicines delivered or administered to the Member by the prescriber or the prescriber's staff are not covered. Injectable drugs are covered under your medical benefit when administered during a Physician's office visit or self-administered pursuant to training by an appropriate health care professional. Refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for more information about medications covered under your medical benefit.
- **Compounded Medication:** Any medicinal substance that has at least one ingredient that is Federal Legend or State Restricted in a therapeutic amount. Compounded medications are not covered unless Preauthorized as Medically Necessary by PacifiCare.
- **Diagnostic Drugs:** Drugs used for diagnostic purposes are not covered. Refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* for information about medications covered for diagnostic tests, services and treatment.
- **Dietary or nutritional** products and food supplements, whether prescription or nonprescription, including vitamins (except prenatal), minerals and fluoride supplements, health or beauty aids, herbal supplements and/or alternative medicine, are not covered. Phenylketonura (PKU) testing and treatment is covered under your medical benefit including those formulas and special food products that are a part of a diet prescribed by a Participating Physician provided that the diet is Medically Necessary. For additional information, refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form.*
- **Drugs prescribed by a dentist** or drugs when prescribed for dental treatment are not covered.
- **Drugs when prescribed to shorten the duration of a common cold** are not covered.
- **Enhancement medications** when prescribed for the following nonmedical conditions are not covered: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging for cosmetic purposes, and mental performance. Examples of drugs that are excluded when prescribed for such conditions include, but are not limited to, Penlac®, Retin-A®, Renova®, Vaniqa®, Propecia®, Lustra®, Xenical® or Meridia®. This exclusion does not exclude coverage for drugs when Preauthorized as Medically Necessary to treat morbid obesity or diagnosed medical conditions affecting memory, including, but not limited to, Alzheimer's dementia.
- **Infertility:** All forms of prescription medication when prescribed for the treatment of infertility are not covered. If your Employer has purchased coverage for infertility treatment, prescription medications for the treatment of infertility may be covered under that benefit. Please refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for additional information.
- **Injectable Medications:** Except as described under the section "Medications Covered by Your Benefit," injectable medications, including, but not limited to, self-injectables, infusion therapy, allergy serum, immunization agents and blood products, are not covered as an outpatient prescription drug benefit. However, these medications are covered under your medical benefit as described in and according to the terms and conditions of your medical *Combined Evidence of Coverage and Disclosure Form.* Outpatient injectable medications administered in the Physician's office (except insulin) are covered as a medical benefit when part of a medical office visit. Injectable medications may be subject to PacifiCare's Preauthorization requirements. For additional information, refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* under "Your Medical Benefits."
- **Inpatient Medications:** Medications administered to a Member while an inpatient in a Hospital or while receiving Skilled Nursing Care as an inpatient in a Skilled Nursing Facility are not covered under this *Pharmacy Schedule of Benefits.* Please refer to Section Five of your medical *Combined Evidence of Coverage and Disclosure Form* titled "Your Medical Benefits" for information on coverage of prescription medications while hospitalized or in a Skilled Nursing Facility. Outpatient prescription drugs are covered for Members receiving Custodial Care in a rest home, nursing home, sanitarium, or similar facility if they are obtained from a Participating Pharmacy in accordance with all the terms and conditions of coverage set forth in this *Schedule of Benefits* and in the Pharmacy *Supplement to the Combined Evidence of Coverage and Disclosure Form.* When a Member is receiving

DENTAL PLAN

Dental Benefits

The Trust provides a prepaid dental plan through Dental Health Services (DHS). Under this dental plan, you must receive services from a network provider in order to receive coverage. Many of the services offered by this dental plan require no copayment. In addition, there is no annual deductible to satisfy.

Enrolling in this dental plan is similar to enrolling in the medical plan previously described. You must complete the appropriate enrollment form and select a dental office.

How to File a Claim for Dental Benefits

No claim forms are required by Dental Health Services. The copayment required for certain services under the prepaid dental plan may be required in full on the date of service.

Please remember that you must select a dental office from your provider directory and include the information on your enrollment form. If you did not select a dentist when you enrolled, a provider may be selected for you.

Please note that copayments must be paid directly to the participating dental office where dental treatment is received. Payments are due on the day of service unless prior arrangements have been made with your dental provider. In the prepaid plan should your treatment plan require the services of a specialist, you must be referred by your chosen family dentist in order to receive coverage.

Dental Health Services Grievance Procedures

Discuss any grievance first with your Dental Health Services dentist. For assistance, you may call a Member Services Representative by calling (800) 637-6453. Grievances involving emergency care are addressed immediately and responded to in writing within three days. If your are not satisfied with the decision from Dental Health Services, you may request a review by notifying Dental Health Services at the following address:

Dental Health Services
Member Services Department
3833 Atlantic Avenue
Long Beach, CA 90807-3505

Complete grievance and appeals procedures are contained in the Evidence of Coverage booklet, which can be obtained, free of charge, by contacting Dental Health Services or the Trust Administration Office.

Dental Health Services

Schedule of Covered Services and Copayments
Plan C3+ - MUST Trust

Services when performed by a Dental Health Services general dentist

Code	Service	Copayment
	Office visit charge - per visit	None
	Failed/no-show appointment without 24-hour notice	20.00

Diagnostic

D0120	Periodic oral evaluation	None
D0140	Limited oral evaluation - problem-focused	None
D0145	Oral evaluation for a patient under three years of age and counseling with primary caregiver	None
D0150	Comprehensive oral evaluation - new or established patient	None
D0160	Detailed and extensive oral evaluation - problem-focused	None
D0170	Re-evaluation - limited, problem-focused	None
D0180	Comprehensive periodontal evaluation	None
D0210	Intraoral - complete series, including bitewings	None
D0220	Intraoral - periapical, first film	None
D0230	Intraoral - periapical, each additional film	None
D0240	Intraoral - occlusal film	None
D0250	Extraoral - first film	None
D0260	Extraoral - each additional film	None
D0270	Bitewing - single film	None
D0272	Bitewings - two films	None
D0273	Bitewings - three films	None
D0274	Bitewings - four films	None
D0277	Bitewings - vertical, seven to eight films	None
D0330	Panoramic film	None
D0425	Caries Susceptibility test	None
D0460	Pulp vitality tests	None
D0470	Diagnostic casts	5.00

Preventive

Dental prophylaxis (teeth cleaning) includes shallow scaling and polishing - eligible once every four months

D1110	Prophylaxis - adult	None
D1120	Prophylaxis - child	None
D1203	Topical application of fluoride - child	None
D1204	Topical application of fluoride - adult	None
D1310	Nutritional counseling for control of dental disease	None
D1330	Oral hygiene instructions	None
D1351	Sealant - per tooth	None

Space maintainers

D1510	Space maintainer - fixed, unilateral	12.00
D1515	Space maintainer - fixed, bilateral	24.00
D1520	Space maintainer - removable, unilateral	12.00
D1525	Space maintainer - removable, bilateral	12.00
D1550	Re-cementation of space maintainer	None

Amalgam restorations - primary or permanent

D2140	Amalgam - one surface, primary or permanent	None
D2150	Amalgam - two surfaces, primary or permanent	None
D2160	Amalgam - three surfaces, primary or permanent	None
D2161	Amalgam - four or more surfaces, primary or permanent	None

Resin-based composite restorations

D2330	One surface, anterior	None
D2331	Two surfaces, anterior	None
D2332	Three surfaces, anterior	None
D2335	Four or more surfaces, or involving incisal angle, anterior	None
D2390	Crown, anterior	30.00
D2391	One surface, posterior	30.00
D2392	Two surfaces, posterior	50.00
D2393	Three surfaces, posterior	70.00
D2394	Four or more surfaces, posterior	90.00

Code	Service	Copayment

Crowns - single restoration only

* Additional charges of $50 for noble metal, $80 for high noble metal. Add $100 for porcelain on molars, $50 for porcelain butt margin. Add $200 per crown for special gold crowns such as Captek, Empress, Procera, etc. Cosmetic-only porcelain crowns/PFM for $580, plus applicable metal upgrade costs, for a maximum of 6 teeth every 5 years.

D2510	Inlay - metallic, one surface	*35.00
D2520	Inlay - metallic, two surfaces	*35.00
D2530	Inlay - metallic, three or more surfaces	*35.00
D2542	Onlay - metallic, two surfaces	*35.00
D2543	Onlay - metallic, three surfaces	*35.00
D2544	Onlay - metallic, four or more surfaces	*35.00
D2610	Inlay - porcelain/ceramic - one surface	*35.00
D2620	Inlay - porcelain/ceramic - two surfaces	*35.00
D2630	Inlay - porcelain/ceramic - three or more surfaces	*35.00
D2642	Onlay - porcelain/ceramic - one surface	*35.00
D2643	Onlay - porcelain/ceramic - two surfaces	*35.00
D2644	Onlay - porcelain/ceramic - three or more surfaces	*35.00
D2650	Inlay - resin-based composite - one surface	35.00
D2651	Inlay - resin-based composite - two surfaces	35.00
D2652	Inlay - resin-based composite - three or more surfaces	35.00
D2662	Onlay - resin-based composite - one surface	35.00
D2663	Onlay - resin-based composite - two surfaces	35.00
D2664	Onlay - resin-based composite - three or more surfaces	35.00
D2710	Resin-based composite - indirect	35.00
D2712	3/4 resin-based composite - indirect	35.00
D2720	Resin with high noble metal	*50.00
D2721	Resin with base metal	50.00
D2722	Resin with noble metal	*50.00
D2740	Porcelain/ceramic	50.00
D2750	Porcelain fused to high noble metal	*50.00
D2751	Porcelain fused to base metal	50.00
D2752	Porcelain fused to noble metal	*50.00
D2780	3/4 cast high noble metal	*50.00
D2781	3/4 cast base metal	50.00
D2782	3/4 cast noble metal	*50.00
D2783	3/4 porcelain/ceramic	100.00
D2790	Full cast, high noble metal	*50.00
D2791	Full cast, base metal	50.00
D2792	Full cast, noble metal	*50.00
D2794	Crown - titanium	50.00

Other restorative services

D2910	Recement inlay, onlay, or partial coverage restoration	None
D2915	Recement cast or prefabricated post and core	None
D2920	Recement crown	None
D2930	Prefabricated stainless steel crown - primary tooth	10.00
D2931	Prefabricated stainless steel crown - permanent tooth	10.00
D2932	Prefabricated resin crown	10.00
D2933	Prefabricated stainless steel crown with resin window	30.00
D2934	Prefabricated coated stainless steel crown - primary tooth	30.00
D2940	Protective restoration	None
D2950	Core buildup, including any pins	None
D2951	Pin retention - per tooth, in addition to restoration	None
D2952	Post and core in addition to crown, indirectly fabricated	None
D2953	Each additional indirectly fabricated post - same tooth	None
D2954	Post and core, in addition to crown	None
D2955	Post removal - not in conjunction with endodontic therapy	55.00
D2957	Each additional pre-fabricated post - same tooth	None
D2960	Labial veneer - resin laminate, chairside	35.00
D2961	Labial veneer - resin laminate, laboratory	50.00
D2962	Labial veneer - porcelain laminate, laboratory	50.00
D2970	Temporary Crown (fractured tooth)	25.00
D2971	Additional procedures to construct new crown	25.00
D2975	Coping	50.00

Code	Service	Copayment

Endodontics

3110	Pulp cap - direct, excluding final restoration	None
3120	Pulp cap - indirect, excluding final restoration	None
3220	Therapeutic pulpotomy, excluding final restoration	None
3221	Pulpal debridement - primary or permanent teeth	None
3230	Pulpal therapy - anterior, primary tooth	20.00
3240	Pulpal therapy - posterior, primary tooth	20.00

Root canal therapy

3310	Endodontic therapy, anterior tooth (excluding final restoration)	20.00
3320	Endodontic therapy, bcuspid tooth (excluding final restoration)	20.00
3330	Endodontic therapy, molar (excluding final restoration)	20.00
3331	Treatment of root canal obstruction - non-surgical	20.00
3332	Incomplete root canal therapy - inoperable, unrestorable, or fractured tooth	20.00
3333	Internal root repair of perforation defects	20.00
3346	Retreatment of root canal therapy - anterior	70.00
3347	Retreatment of root canal therapy - posterior	120.00
3348	Retreatment of root canal therapy - molar	170.00
3351	Apexification/recalcification - initial visit	None
3352	Apexification/recalcification - interim visit	None
3353	Apexification/recalcification - final visit	None
3410	Apicoectomy - anterior	20.00
3421	Apicoectomy - bicuspid (first root)	20.00
3425	Apicoectomy - molar (first root)	20.00
3426	Apicoectomy - each additional root	20.00
3430	Retrograde filling - per root	None
3950	Canal preparation and fitting of pre-formed dowel or post	None

Periodontics

4210	Gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	25.00
4211	Gingivectomy or gingivoplasty - one to three contiguous teeth, or tooth bounded spaces per quadrant	None
4240	Gingival flap procedure, with root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	300.00
4241	Gingival flap procedure, with root planing - one to three contiguous teeth or tooth bounded spaces, per quadrant	200.00
4245	Apically positioned flap	200.00
4249	Clinical crown lengthening - hard tissue	200.00
4260	Osseous surgery - four or more contiguous teeth or tooth bounded spaces per quadrant	300.00
4261	Osseous surgery - one to three contiguous teeth or tooth bounded spaces per quadrant	200.00
4271	Free soft tissue graft procedure	275.00
4341	Scaling and root planing - four or more teeth per quadrant	None
4342	Scaling and root planing - one to three teeth per quadrant	None
4355	Full mouth debridement to enable evaluation and diagnosis	None
4381	Crevicular tissue treatment - per tooth	50.00
4910	Periodontal maintenance	None

Dentures

Dentures and partials include four months free adjustments. Add lab cost of any gold. Add $200 for soft, flexible dentures such as Valplast, Thermoflex, Flexite, etc. (except for procedures 5225 and 5226).

5110	Complete denture - upper	65.00
5120	Complete denture - lower	65.00
5130	Immediate denture - upper	65.00
5140	Immediate denture - lower	75.00
5211	Upper partial denture - resin base, including clasps, rests, teeth	75.00
5212	Lower partial denture - resin base, including clasps, rests, teeth	75.00
5213	Upper partial denture - cast metal framework with resin denture bases, including clasps, rests, teeth	75.00
5214	Lower partial denture - cast metal framework with resin denture bases, including clasps, rests, teeth	75.00
5225	Upper partial denture - flexible base, including clasps, rests, teeth	275.00
5226	Lower partial denture - flexible base, including clasps, rests, teeth	275.00
5281	Removable unilateral partial denture - one piece cast metal, including clasps, teeth	50.00

Code	Service	Copayment

Denture adjustments & repairs

5410	Adjust complete denture - upper	None
5411	Adjust complete denture - lower	None
5421	Adjust partial denture - upper	None
5422	Adjust partial denture - lower	None
5510	Repair broken complete denture base	5.00
5520	Replace missing or broken teeth - per tooth	5.00
5610	Repair resin denture base	5.00
5620	Repair cast framework	5.00
5630	Repair or replace broken clasp	None
5640	Replace broken teeth - per tooth	5.00
5650	Add tooth to existing partial denture	5.00
5660	Add clasp to existing partial denture	5.00
5670	Replace all teeth and acrylic on cast metal - upper	145.00
5671	Replace all teeth and acrylic on cast metal - lower	145.00
5710	Rebase complete upper denture	None
5711	Rebase complete lower denture	None
5720	Rebase partial upper denture	None
5721	Rebase partial lower denture	None
5730	Reline complete upper denture - chairside	10.00
5731	Reline complete lower denture - chairside	10.00
5740	Reline partial upper denture - chairside	10.00
5741	Reline partial lower denture - chairside	10.00
5750	Reline complete upper denture - laboratory	10.00
5751	Reline complete lower denture - laboratory	10.00
5760	Reline partial upper denture - laboratory	10.00
5761	Reline partial lower denture - laboratory	10.00
5810	Temporary complete upper denture	45.00
5811	Temporary complete lower denture	45.00
5820	Temporary partial upper denture	45.00
5821	Temporary partial lower denture	45.00
5850	Tissue conditioning - upper	20.00
5851	Tissue conditioning - lower	20.00

Bridges

* Additional charges of $50 for noble metal, $80 for high noble metal. Add $100 for porcelain on molars, $50 for porcelain butt margin. Add $200 per crown for special gold crowns such as Captek, Empress, Procera, etc. Cosmetic-only porcelain crowns/PFM for $580, plus applicable metal upgrade costs, for a maximum of 6 teeth every 5 years.

6205	Pontic - indirect resin-based composite	45.00
6210	Pontic - cast high noble metal	*45.00
6211	Pontic - cast predominantly base metal	45.00
6212	Pontic - cast noble metal	*45.00
6214	Pontic - titanium	45.00
6240	Pontic - porcelain fused to high noble metal	*45.00
6241	Pontic - porcelain fused to base metal	45.00
6242	Pontic - porcelain fused to noble metal	*45.00
6245	Pontic - porcelain/ceramic	50.00
6250	Pontic - resin with high noble metal	*45.00
6251	Pontic - resin with base metal	45.00
6252	Pontic - resin with noble metal	*45.00
6545	Maryland bridge retainer, per unit	45.00
6548	Retainer - porcelain/ceramic - resin-bonded prosthesis	50.00
6600	Inlay - porcelain/ceramic, two surfaces	50.00
6601	Inlay - porcelain/ceramic, three or more surfaces	50.00
6602	Inlay - cast high noble metal, two surfaces	*35.00
6603	Inlay - cast high noble metal, three or more surfaces	*35.00
6604	Inlay - cast base metal, two surfaces	35.00
6605	Inlay - cast base metal, three or more surfaces	35.00
6606	Inlay - cast noble metal, two surfaces	*35.00
6607	Inlay - cast noble metal, three or more surfaces	*35.00
6608	Onlay - porcelain/ceramic, two surfaces	50.00
6609	Onlay - porcelain/ceramic, three or more surfaces	50.00
6610	Onlay - cast high noble metal, two surfaces	*35.00
6611	Onlay - cast high noble metal, three or more surfaces	*35.00
6612	Onlay - cast base metal, two surfaces	35.00
6613	Onlay - cast base metal, three or more surfaces	35.00
6614	Onlay - cast noble metal, two surfaces	*35.00
6615	Onlay - cast noble metal, three or more surfaces	*35.00
6624	Inlay - titanium	45.00
6634	Onlay - titanium	45.00

Code	Service	Copayment
6710	Crown - indirect resin-based composite	35.00
6720	Crown - resin with high noble metal	*35.00
6721	Crown - resin with base metal	35.00
6722	Crown - resin with noble metal	*35.00
6740	Crown - porcelain/ceramic	50.00
6750	Crown - porcelain fused to high noble metal	*50.00
6751	Crown - porcelain fused to base metal	50.00
6752	Crown - porcelain fused to noble metal	*50.00
6780	Crown - 3/4 cast high noble metal	*50.00
6781	Crown - 3/4 cast base metal	50.00
6782	Crown - 3/4 cast noble metal	*50.00
6783	Crown - 3/4 porcelain/ceramic	100.00
6790	Crown - full cast high noble metal	*50.00
6791	Crown - full cast base metal	50.00
6792	Crown - full cast noble metal	*50.00
6794	Crown - titanium	45.00
6930	Re-cement fixed partial denture	None
6970	Post and core in addition to fixed partial denture retainer, indirectly fabricated	*None
6972	Prefabricated post and core	None
6973	Core build up for retainer - including any pins	None
6975	Coping - metal	*10.00
6976	Each additional indirectly fabricated post - same tooth	None
6977	Each additional prefabricated post - same tooth	None

Oral surgery

7111	Extraction - coronal remnants, deciduous tooth	None
7140	Extraction - erupted tooth or exposed root	None
7210	Surgical removal of erupted tooth	5.00
7220	Removal of impacted tooth - soft tissue	15.00
7230	Removal of impacted tooth - partially bony	40.00
7240	Removal of impacted tooth - completely bony	40.00
7241	Removal of impacted tooth with unusual surgical conditions	90.00
7250	Surgical removal of residual tooth roots	5.00
7270	Tooth reimplantation and/or stabilization	50.00
7282	Mobilization of erupted or malpositioned tooth	5.00
7310	Alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	None
7311	Alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	None
7320	Alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces	None
7321	Alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	None
7510	Incision and drainage of abscess	None
7511	Incision and drainage of abscess - complicated	50.00

Other services

9110	Emergency treatment - minor procedure	25.00
9215	Local anesthesia	None
9310	Second opinion consultation	20.00
9440	Office visit - after regularly scheduled hours	25.00
9450	Case presentation - detailed	None
9630	Other medicaments, intra-sulcular irrigation	25.00
9910	Root desensitizing	5.00
9911	Cervical/root desensitizing, per tooth	5.00
9940	Occlusal guard - by report	120.00
9941	Fabrication of athletic mouthguard	60.00
9942	Repair and/or reline of occlusal guard	60.00
9971	Odontoplasty - one or two teeth	5.00
9972	External bleaching - per arch	200.00
9973	External bleaching - per tooth	100.00
9974	Internal bleaching - per tooth	100.00

Code	Service	Copayment

Services when performed by a Dental Health Services orthodontist

Please call your Member Service specialist at 800.637.6453 for a referral to the nearest participating orthodontist

Orthodontics

Consultation	25.00
Failed/no-show appointment without 24-hour notice	25.00
Full banded - child, up to age 19	1775.00
Full banded - adult	1975.00
Partial banded - child, up to age 19	1250.00
Partial banded - adult	1450.00
Mixed dentition - phase I	450.00
Palatal expansion	350.00
Rapid palatal expansion	550.00
Retention appliance - after orthodontic treatment	180.00
Functional appliance (Bionator-Frankel)	550.00
Headgear	350.00
Simple crossbite	275.00
Copying records	40.00

Dental exclusions

The following services are not covered by your dental plan

A. Services that are not consistent with professionally recognized standards of practice.

B. Services related to implants or attachments to implants.

C. Cosmetic services, for appearance only, unless specifically listed. Plan covers cosmetic-only porcelain crowns/PFM, when deemed appropriate by the participating dentist, for $580 plus applicable metal upgrade costs, for a maximum of 6 teeth every 5 years.

D. Myofunctional therapy-procedures for training, treating or developing muscles in and around the jaw or mouth including T.M.J. and related diseases, except for occlusal guard.

E. Treatment for malignancies, neoplasms (tumors) and cysts as well as hereditary, congenital and/or developmental malformations.

F. Dispensing of drugs not normally supplied in a dental office.

G. Hospitalization charges, dental procedures or services rendered while patient is hospitalized.

H. Procedures, appliances or restorations (other than fillings) that are necessary for full mouth rehabilitation, to increase arch vertical dimension, or crown/bridgework requiring more than 10 crowns/pontics. Replacement or stabilization of tooth structure lost through attrition, abrasion or erosion. Procedures performed by a prosthodontist.

I. Fixed bridges for patients under the age of sixteen, in the presence of non-supportive periodontal tissue, when edentulous spaces are bilateral in the same arch, when replacement of more than four teeth in an arch, replacement of missing third molars, or when the prognosis is poor.

J. General anesthesia, including intravenous and inhalation sedation.

K. Dental procedures that cannot be performed in the dental office due to the general health and/or physical limitations of the member.

L. Expenses incurred for dental procedures initiated prior to member's eligibility with Dental Health Services, or after termination of eligibility.

M. Services that are reimbursed by a third party (such as the medical portion of an insurance/health plan or any other third party indemnification).

N. Extractions of non-pathologic, asymptomatic teeth, including extractions and/or surgical procedures for orthodontic reasons.

O. Setting of a fracture or dislocation, surgical procedures related to cleft palate, micrognathia or macrognathia, and surgical grafting procedures.

P. Coordination of benefits with another prepaid managed care dental plan.

Q. Orthodontic treatment of a case in progress and/or retreatment of orthodontic cases.

R. Cephalometric x-rays, tracings, photographs and orthodontic study models.

S. Replacement of lost or broken orthodontic appliances.

T. Changes in orthodontic treatment necessitated by an accident of any kind.

U. Malocclusions so severe or mutilated which are not amenable to ideal orthodontic therapy.

V. Services not specifically covered on the Schedule of Covered Services and Copayments.

Dental limitations

Restrictions on benefits are applied to the following services

A. Treatment of dental emergencies is limited to treatment that will alleviate acute symptoms and does not cover definitive restorative treatment including, but not limited to root canal treatment and crowns.

B. Optional services: when the patient selects a plan of treatment that is considered optional or unnecessary by the attending dentist, the additional cost is the responsibility of the patient.

C. Routine teeth cleaning (prophylaxis) is limited to once every four months and full mouth x-rays are limited to one set every three years if needed.

D. Periodontal scaling and root planing (deep cleaning) is limited to once every four months

E. Sealants are only a benefit for permanent posterior teeth of children under the age of eighteen.

F. Covered specialist referrals must be pre-approved by Dental Health Services.

G. Periodontal surgical procedures are limited to four quadrants every two years.

H. There are additional charges for precious/noble metals (gold).

I. Replacement will be made of any existing appliance (denture, etc.) only if it is unsatisfactory and cannot be made satisfactory. Prosthetic appliances will be replaced only after five years have elapsed from the time of delivery. Lost or stolen removable appliances are the responsibility of the enrollee.

J. Relines are limited to once per twelve months, per appliance.

K. Single unit inlays and crowns are a benefit as provided above only when the teeth cannot be adequately restored with other restorative materials.

L. The maximum benefit for pedodontic specialty care is $500 per year.

Enrollees should refer to the Group Service Agreement for further information on benefit exclusions and limitations.

Orthodontic exclusions

A. Retreatment of orthodontic cases.

B. Treatment of a case in progress at inception of eligibility.

C. Surgical procedures (including extraction of teeth) incidental orthodontic treatment.

D. Surgical procedures related to cleft palate, micrognathia or macrognathia.

E. Treatment related to temporomandibular joint (TMJ) disturbances and/or hormonal imbalances.

F. Any dental procedure considered within the field of general dentistry, including but not limited to: myofunctional therapy; general anesthetics, including intravenous and inhalation sedation; dental services of any nature performed in a hospital.

Orthodontic limitations

The following are subject to additional charges

A. Cephalometric x-rays, dental x-rays.

B. Tracings and photographs.

C. Study models.

D. Replacement of lost or broken appliances.

E. Changes in treatment necessitated by an accident of any kind.

F. Services which are compensable under worker's compensation or employer liability laws.

G. Malocclusions so severe or mutilated they are not amenable to ideal orthodontic therapy.

H. Full banded treatments are based on a 24-month standard treatment plan. Additional treatment, or treatment that extends beyond that time may be subject to additional charges.

If the contract between the group and Dental Health Services is terminated, service is subject to a pro-rated fee based on current market value for the balance of orthodontic treatment. If the member should terminate group coverage, they are no longer eligible for the group orthodontic rate.

Should the contract between Dental Health Services and the orthodontist terminate, any Dental Health Services members in treatment would not be subject to proration.

Please call your Member Service specialist at 800.637.6453 for a referral to the nearest participating orthodontist.

Health plan benefits and coverage matrix

THIS MATRIX IS INTENDED TO BE USED TO HELP YOU COMPARE COVERAGE BENEFITS AND IS A SUMMARY ONLY. THE EVIDENCE OF COVERAGE AND PLAN CONTRACT SHOULD BE CONSULTED FOR A DETAILED DESCRIPTION OF COVERAGE BENEFITS AND LIMITATIONS.

Deductibles: None

Lifetime maximums: Pedodontic specialty services have a lifetime maximum of $500. There are no other maximums.

Professional services - exam & preventive services: No charge for most services. Full mouth x-rays limited to every three years. Prophylaxis (cleanings) limited to every six months. Sealants limited to permanent teeth to age 18.

Professional services - restorative, crowns, endodontics and oral surgery services: Copayments for fillings, caps, root canals and extractions vary by procedure in the enclosed Schedule.

Professional services - periodontic services: Copayments for gum treatments vary by procedure in the enclosed Schedule. Surgical procedures are limited to four quads every two years.

Professional services - dentures and partial dentures: Copayments vary by procedure and appear in the enclosed Schedule. Replacements limited to every five years. Relines limited to every 12 months.

Professional services - specialty services: Copayments vary by procedure and appear in the enclosed Schedule of Covered Services and Copayments.

Outpatient office visits: No additional charge

Hospitalization services: Not covered

Prescription drug coverage: Not covered

Emergency health services: Not covered

Ambulance services: Not covered

Durable medical equipment: Not covered

Mental health services: Not covered

Chemical dependency services: Not covered

Home health services: Not covered

This dental plan does not provide general anesthesia. Members requiring general anesthesia should inquire with their medical plan for coverage.

These benefits can only be changed by Dental Health Services with 30 days prior notice given to the group, and with the group's consent to the proposed changes.

DAVISVISION
SEE LIFE

Vision Care Plan Benefit Description

$5

Eye Examination Copayment

Premier Plan

Please call Davis Vision at **1-800-999-5431** *with questions or visit our website:* **www.davisvision.com**

The vision program enables you and your covered dependents to receive quality vision care services. Eligibility for vision care benefits is determined by the same rules that apply to your other health care benefits.

How do I receive services from a provider in the network?

- Call the network provider of your choice and schedule an appointment.
- Identify yourself as a member of the Davis Vision plan.
- Provide the office with the member ID number and the name and date of birth of any covered dependent needing services.

It's that easy! The provider's office will verify your eligibility for services, and claim forms or ID cards are not required!

Who are the network providers?

They are licensed providers in both private practice and retail locations who are extensively reviewed and credentialed to ensure that stringent standards for quality service are maintained. Please access Davis Vision's website at **www.davisvision.com** and utilize the "Find a Doctor" feature, or call **1-800-999-5431** to access the Interactive Voice Response (IVR) Unit, which will supply you with the names and addresses of the network providers nearest you.

What are the plan benefits, frequencies and costs?

EYE EXAMINATIONS . . . . . .Every 12 months, including dilation as professionally indicated.
In-Network Copayment $5

EYEGLASSES . . . . . Every 12 months
In-Network Copayment $0
You may choose any Fashion, Designer or Premier level frame from Davis Vision's Frame Collection, covered in full. Or, if you select another frame in the network provider's office, a $150 credit plus a 20% discount off the overage will be applied. This credit would also apply at retail locations that do not carry the Frame Collection. Members are responsible for the amount over $150. For more information on lenses, please see "What lenses/coatings are included?".
Out-of-Network . . . . . Reimbursed up to $25 for frames, up to $35 for single vision lenses, up to $45 for bifocals, up to $55 for trifocals lenses.

CONTACT LENSES . . . . . Every 12 months
In-Network Copayment $0
In lieu of eyeglasses, you may select contact lenses. Any contact lenses from Davis Vision's Contact Lens Collection will be covered in full per the number indicated below. If you select contact lenses, your evaluation, fitting and follow up care will also be covered. Davis Vision Contact Lens Collection (includes evaluation, fitting, follow-up):
Standard/Daily Wear . . . . . .One pair of lenses
Disposable . . . . . Four boxes/multi-packs
Planned Replacement . . . . . Two boxes/multi-packs
In lieu of the Davis Vision contact lenses, members may use their $150 credit plus a 15% discount to go toward the provider's own supply of contact lenses, evaluation, fitting and follow-up care. This credit would also apply towards all

contact lenses received at participating retail locations. Medically necessary contact lenses will be covered in full with prior approval.
Out-of-Network . . . . . Reimbursed up to $55

SAFETY EYEGLASSES

MEMBERS ONLY . . . . . .Every 12 months
Copayment $0
In-Network . . . . . Safety frame from the Premier Safety Collection available at network provider's offices, in lieu of the dress benefit.

What lenses/coatings are included?

• Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range.
• Glass grey #3 prescription lenses.
• Oversize lenses.
• Post-cataract lenses.
• Fashion, sun or gradient tinted plastic lenses.
• Polycarbonate lenses for dependent children, monocular patients, and patients with prescriptions +/- 6.00 diopters or greater.
• Scratch-resistant coating.

Are there any optional frames, lens types or coatings available?

	Dress	Safety
• Anti-reflective coating		
Standard	$35	$35
Premium	$48	N/A
Ultra	$60	N/A
• Scratch Protectcion Plan		
Single Vision	$20	N/A
Multifocal	$40	N/A
• Plastic photosensitive lenses	$65	$65
• High-index lenses	$55	$55
• Ultraviolet (UV) coating	$12	Included
• Blended segment lenses	$20	$20
• Intermediate vision lenses	$30	$30
• Polycarbonate lenses	$30	Included
• Glass photochromic lenses.	$20	$20
• Polarized lenses	$75	$75
• Progressive addition multifocal lenses.*		
standard types	$50	$50
premium types	$90	$90

** Progressive addition multifocals can be worn by most people. Conventional bifocals will be supplied at no additional cost for anyone who is unable to adapt to progressive addition lenses, however, the copayment is not refundable.*

When will I receive my eyewear?

Generally, your eyewear will be delivered to your provider from the laboratory within five business days. More delivery time maybe needed when out-of-stock frames, anti-reflective coating, specialized prescriptions or a participating provider's frame is selected.

What about out-of-network provider benefits?

You may receive services from an out-of-network provider, although you will receive the greatest value and maximize your benefit dollars if you select a provider who participates in the network. If you choose an out-of-network provider, you must pay the provider directly for all charges and then submit a claim for reimbursement to:

Vision Care Processing Unit
P.O. Box 1525
Latham, NY 12110

Only one claim per service may be submitted for reimbursement each benefit cycle. To request claim forms, please visit the Davis Vision Web site at **www.davisvision.com** or call 1-800-999-5431.

May I use the benefit at different times?

To maintain continuity of care, we recommend that all available services be obtained at one time from either a network or an out-of-network provider.

Information about Laser Vision Correction Services:

Davis Vision provides you and your eligible dependents with the opportunity to receive Laser Vision Correction Services at discounts of up to 25% off a participating providers normal charges, or 5% off any advertised special (please note that some providers have flat fees equivalent to these discounts). Please check the discount available to you with the participating provider. For more information, please visit us at **www. davisvision.com** or call 1-800-999-5431.

Mail Order Contact Lenses:

Free membership and access to a mail order replacement contact lens service, Lens 123, providing a fast and convenient way to purchase replacement contact lenses at significant savings. For more information, please call 1-800-LENS-123 (1-800-536-7123) or visit the Lens 123 website at www.Lens123.com.

Warranty Information:

One-year eyeglass breakage warranty included at no additional cost All plan eyeglasses come with a breakage warranty for repair or replacement of the frame and/or lenses for a period of one year from the date of delivery.The warranty applies to all plan covered eyeglasses, i.e. spectacle lenses, Davis Vision Collection frames and national retailer frames (where our exclusive Collection is not displayed).

Are there any exclusions?

The following items are not covered by this vision program:

- Medical treatment of eye disease or injury.
- Vision therapy.
- Special lens designs or coatings, other than those previously described.
- Replacement of lost eyewear.
- Non-prescription (plano) lenses.
- Services not performed by licensed personnel.
- Contact lenses and eyeglasses in the same benefit cycle.

For more information, please visit Davis Vision's website at www.davisvision.com or call Davis Vision at 1-800-999-5431 to:

- Learn about the Davis Vision company.
- Access the Interactive Voice Response Unit which will provide network providers nearest you.
- Verify eligibility for you or your family members.
- Request an out-of-network provider reimbursement form.
- Speak with a Member Service Representative.
- Ask any questions about your Vision Care benefits.
- Member Service Representatives are available:
- Monday through Friday, 5:00 AM to 8:00 PM, Pacific Time,
- Saturday, 6:00 AM to 1:00 PM Pacific Time.
- Sunday, 9:00 AM to 1:00 PM Pacific Time.

Participants who use a TTY (Teletypewriter) because of a hearing or speech disability may access TTY services by calling **1-800-523-2847**.

Your rights as a patient:

Davis Vision recognizes that all patients have specific rights, including, but not limited to:

- The right to complete information about their healthcare options and consequences.
- The right to participate in all treatment decisions.
- The right to dignity, privacy, confidentiality and non-discrimination.
- The right to complain or appeal any decision.

Patients also have the responsibility:

- To provide complete and accurate information.
- To follow care instructions.

For a complete copy of *Your Rights and Responsibilities As a Patient*, please visit our website at:**www.davisvision.com** or call 1-800-999-5431.

Employees enrolled in the Davis Vision Plan have the choice of seeing a network or out-of-network licensed optometrist or ophthalmologist, however most services are covered in full, less any applicable copayment, when received from a network or contracted provider. If you obtain services from an out-of-network provider, you will be reimbursed by Davis Vision Plan in accordance with the allowance schedule, less any applicable copayments, once the appropriate claim form is submitted. Claim forms for out-of-network services can be obtained by calling (800) 999-5431 or by accessing the Davis Vision Plan website at www.davisvision.com. No claim forms are required for services rendered by a contracted provider.

Davis Vision Plan Grievance Process

Complaints and grievances regarding access to care, quality of care, or treatment or service should be directed to Davis Vision Plan by calling (800) 999-5431. Complete grievance and appeals procedures are contained in the Evidence of Coverage booklet, which can be obtained, free of charge, by contacting Davis Vision Plan or the Trust Administration Office.

Call 1-800-327-4103 to access services or get a referral.
All calls are confidential.

IT'S ABOUT YOU: The services are designed to help you manage life's challenges. At MHN, we customize solutions by understanding your unique needs and then offering the appropriate assistance or referrals.

CLINICAL COUNSELING:

3 face-to-face consultations per issue, per benefit period

Unlimited telephonic counseling

WORK & LIFE SERVICES:

Telephonic consultations are available in the following areas:

Childcare and eldercare assistance – Needs assessment plus referrals to childcare and eldercare facilities

Financial services – Budgeting, credit and financial guidance (investment advice, loans and bill payments not included), retirement planning and assistance with tax issues

Legal services – Telephonic or face-to-face consultations for issues relating to civil, consumer, personal and family law, financial matters, business law, real estate, estate planning and more (excluding disputes or actions between you and your employer, union, trust fund, or MHN)

Identity theft recovery services – Information on ID theft prevention, plus an ID theft emergency response kit and help from a fraud resolution specialist if you are victimized

Daily living services – Referrals to consultants and businesses that can help with everyday errands, travel, event planning and more (does not cover the cost nor guarantee delivery of services)

ONLINE MEMBER SERVICES;

With the click of a mouse, you can access information and tools online:
- **Search for an MHN counselor and get a referral**
- **Manage your stress with interactive tools**
- **Take a health risk assessment**
- **Ask our expert an emotional health question**
- **Access childcare and eldercare directories**

The website also has information and tools on:
- **Communication and relationships**
- **Depression and anxiety**
- **Substance abuse**
- **Grief and loss**

To get started, visit: members.mhn.com and register with access code "must"

MHN
A Health Net Company℠

	In Network	Out of Network
Outpatient Benefit	Plan pays 100% of contract rate	None
Outpatient Maximum Session Max / Year In / Out Combined ? **No**	No limit on sessions	None
Mental Health Inpatient	Plan pays 100% of contract rate	None - See note
Substance Abuse Treatment Penalty for not completing SA Treatment? **No**	Plan pays 100% of contract rate	None - See note
Concurrent Review Required?	Yes	N/A
Discharge Planning Required?	Yes	N/A
Inpatient Maximums Mental Health Days / Dollars Substance Abuse Days / Dollars	Non-Parity Mental Health Inpatient: 30 days annual Parity Mental Health Inpatient: No limit on sessions Substance Abuse: 1 episode per year	N/A
Detox / Rehab Combined ? **Yes**		
MH/SA Combined? **No**		
Substance Abuse Episode Max In / Out Combined? **No**		
Deductible Individual Family Apply to all services? **Yes**	None None	N/A
Out of Pocket Maximum Individual Family Apply to all services? **Yes**	 $1500 $2000	N/A
Lifetime Maximum Apply to all services? **No**	Non-Parity Mental Health Inpatient: Annual limits only Parity Mental Health Inpatient: No lifetime day limits Substance Abuse: 3 episodes per lifetime	N/A
Penalty for no pre-authorization?		
Outpatient? **Yes**	**Penalty Description:** No payment	**Penalty Description:** N/A
Mental Health Inpatient: **Yes**	**Penalty Description:** No payment	**Penalty Description:** N/A
Substance Abuse: **Yes**	**Penalty Description:** No payment	**Penalty Description:** N/A

NOTE: There is a limited emergency OON benefit that is applicable only if MHN is notified within 24 hours and the services are medically necessary and appropriate. The benefit limits reimbursement of out-of-network emergency Inpatient Mental Health admissions to $500/day and $100/day for the attending psychiatrist or psychologist. Reimbursement of OON emergency Substance Abuse admissions is limited to $300/day. Annual out-of-pocket maximums for all services are $1,500 per individual and $2,000 per family.

MHN
A Health Net Company℠

Aetna®

MULTI UNION SECURITY TRUST FUND
BASIC LIFE/AD&D,
DEPENDENT LIFE
SUMMARY OF BENEFITS

Eligibility	You are in an eligible Class if you: work the required number of employment hours for eligibility for a Participating Employer who makes the required monthly contributions to the Trust on their behalf; and are in a job classification covered by the terms of a collective agreement between the Participating Employer and the Union.
Eligibility Waiting Period	The date you qualify for benefits under the Trust Fund eligibility rules.
Actively At Work Definition	A participant must be "Available for Work" on the participant's effective date of coverage in order to be eligible for coverage under this Plan. A participant will be considered "Available for Work" if he or she meets the eligibility requirements set forth by the Trust Fund eligibility rules. Any participant eligible for coverage under this Plan, but not available for work, will be covered on a premium paying basis.
Basic Term Life Insurance	Your Basic Term Life and Accidental Death & Dismemberment Insurance coverage equal to: Members- Flat $50,000 Dependent Spouse*: $1,000 Unmarried child from live birth***: $1,000 *but not more than 50% of the amount of your Life Insurance under this Plan. **Any unmarried child under age 25 who goes to school on a regular basis and depends solely on you for support will be covered as a dependent. However, coverage is not provided for dependents in full-time military service. Your children include: biological, adopted, stepchildren.
Accidental Death and Dismemberment (AD&D)	All Members: Flat $50,000
Life Benefit Features	Conversion If you terminate employment, are no longer eligible for coverage, or your coverage reduces due to age, pension or retirement, you have the opportunity to purchase an individual conversion life insurance policy within 31 days of your termination in coverage. Premium Waiver If you cease active work due to a permanent and total disability before reaching age 60, your life insurance may be extended at no cost to you or your employer once you have completed a 9 month waiting period. If your claim is approved, your life insurance will continue until the earlier of the date you recover, the date you fail to show Aetna proof that you are still disabled; you reach the amended 1983 Social Security Retirement Age or date of retirement.
AD&D Benefit Features	Coma Benefit If a covered employee suffers a bodily injury caused by an accident and as a direct result becomes comatose, a monthly benefit of 5% of the Principal Sum less any benefit amount paid or payable because of the same accident will be payable for 11 months after the person has been continually comatose for at least 30 consecutive days. After 12 months of continuous coma, the full Principal Sum less any benefit amount paid or payable because of the same

	accident is payable. Monthly benefit payments terminate on the earliest of the date all monthly payments have been made; the full Principal Sum is paid; the coma ceases; failure to have any required exam or to give proof of continuous coma; the policy terminates. Passenger Restraint and Airbag If a covered loss of life of the employee occurs as a direct result of a motor vehicle accident and the insured is properly using a passenger restraint and (if the driver) is properly licensed, a benefit will be payable. If an airbag is activated as a result of the same accident, an additional benefit will be payable. Passenger restraint and airbag usage will require verification. The benefit provides for $10,000 for use of a passenger restraint and an additional $5,000 if an airbag is activated. Education Benefit If a loss of life of the employee occurs as a direct result of an accident, an education benefit will be payable on behalf of each dependent child and/or a surviving spouse for a maximum of 4 years from the date of death, with verification of continued enrollment. The benefit provides for 5% of employee's principal sum not to exceed $5,000 per year. Child Care If a loss of life of the employee occurs as a direct result of an accident, a benefit will be payable to the guardian of the estate of the child, or to the custodian, or adult caretaker, to cover expenses associated with the dependent child's enrollment in a legally licensed child care center as of the date of the accident or subsequently enrolled within 90 days of the accident. The benefit is payable for a maximum of 4 years from the date of death, with verification of continued enrollment. The benefit provides for 3% of the employee's principal sum to a maximum of $2000 per child per year. Repatriation of Remains If a covered loss of life of the employee occurs as a direct result of an accident while he/she is at least 200 miles from home, a benefit will be payable for the preparation and transportation of the body to a hometown mortuary. The benefit provides for $5,000 to prepare and transport the body.
Aetna Life Essentials *(At-no-cost)*	You now have access to benefits and services that can help you make the most of every stage of your life. Your life insurance includes new features that help you live fully today and better prepare for tomorrow. Caring support and resources We'll help by providing emotional and financial support during end of life – for you, your family and caregivers. • Resources when they are needed most – If you or your covered spouse becomes terminally ill, you can get up to 75% of your life insurance benefit amount ahead of time. You can receive these benefits if your doctors determine your life expectancy will likely not exceed 24 months. You can use the money to pay medical and other bills during an illness to help preserve your life savings. • Financial Planning Services* – Through an arrangement with JP Morgan Chase*, active employees, retirees and beneficiaries of deceased life members have access

to certain financial planning services and advice at no additional cost to you.

- Legal Services* – Through the Legal Reference®** Program, employees and their spouses have access to certain on-line estate planning services. On-line services available include:
  - Living wills
  - Health care directives
  - Durable financial power of attorney
  - Basic will preparation services (two annually)

  Terminally ill Supplemental life members will have access to several additional estate planning services, delivered in the attorney's office and paid in full:
  - Will preparation
  - Health care power of attorney document preparation
  - Durable financial power of attorney document preparations
  - Uncontested guardianship documentation
  - Tax planning preparation
  - Legal representation for the real estate sale of primary residence

- Emotional Services* – We want to help you, not only financially, but emotionally. That's why we provide you, your family members, beneficiaries and caregivers with access to the Compassionate Care Website and bereavement and grief counseling services.

Life Essentials website: www.aetna.com/group/aetna_life_essentials

* Securities (including mutual funds and variable annuities) and investment advisory services are offered through Chase Investment Services Corp, (CISC) or affiliated broker/dealers. Annuities and insurance products are provided by various insurance companies and offered through Chase Insurance Agency, Inc. (CIA), a licensed insurance agency, doing business as Chase Insurance Agency Services, Inc. in Florida. CISC, a member of NASD/SIPC, and CIA are affiliates of JPMorgan Chase Bank, N.A. Products not available in all states. JPMorgan Chase Bank, N.A., and its affiliates do not offer legal or accounting advice to their clients. Clients are urged to consult with their own legal, accounting and tax advisors with respect to their specific situations. Aetna does not warrant or guarantee and makes no representations as to the quality of services offered by CISC.

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*This particular Aetna Life Essentials program feature is not insurance, is provided at no additional cost to you, and may be changed or discontinued at any time by Aetna without notice. Additional program limitations and restrictions apply.