Multi Union Security Trust Fund

Fort Irwin

General Information Booklet

Summary Plan Description
Eligibility and Benefits

Effective February 1, 2017

AVISOS A LOS PARTICIPANTES DEL HABLA HISPANA

Si tiene preguntas respecto a lo contenido en este Resumen en *la* Descripción del Plan y se siente más cómodo 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 ADMINISTRATIVE OFFICE

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

FOREWORD

This Summary Plan Description (SPD) 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 ADMINISTRATIVE 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 Administrative Office.

Generally, this booklet is given to everyone who is entitled to receive a copy. Because of this, you may receive a SPD 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: Anthem Blue Cross (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 Administrative Office, and are subject to final interpretations by the Trustees. Any questions regarding the specific benefits summarized in this booklet 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 benefit plans available. If there is a conflict between this summary and any specific benefit plan, the provisions of the specific plan shall govern. However, this SPD is the governing Plan Document, setting out the terms of eligibility, suspension, and termination of coverage.

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 TRUST AND 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 the quality of the health-care services or supplies furnished by any provider.

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 Anthem Blue Cross, Dental Health Services, Davis Vision, Managed Health Network (MHN), and Aetna Life Insurance Company.

HEALTH CARE REFORM

The Trust is not grandfathered as that term is defined in the Patient Protection and Affordable Care Act (Affordable Care Act).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.

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 or add dependents, but only once in any twelve-month period.

Provider means the carriers or providers of service to the Trust as listed on page 25 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 Administrative 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

You are eligible to receive benefits on the first of the month in which employer contributions are remitted, provided you complete and submit the appropriate enrollment forms as set out in the SPD. As long as such employer contributions continue to be paid on your behalf, you will maintain your eligibility under 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 contact the Trust Administrative Office for additional information about eligibility rules that apply to you.

Enrollment for Benefits

Please contact the Trust Administrative Office to ask for a SPD or Schedule of Benefits for the Trust to learn more about the medical and dental plans available to your group. 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. If your Employer does not provide you with an enrollment packet contact the Trust Administrative Office by calling (800) 753-0222.

You cannot be properly enrolled for benefits until the Trust Administrative 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 Administrative Office immediately. Coverage may be denied if the appropriate HMO enrollment form is not received by the Trust Administrative Office within 30 days from the date you become eligible.

All eligible Employees are required to be covered for benefits under the Multi Union Security Trust, unless the Employee has complied with the Plan Opt Out Rule on page 2 of this SPD. Therefore, if your employer has reported you as eligible, but a completed enrollment form is not provided to the Trust Administrative Office within 30 days from the date you become eligible, you may be automatically enrolled in the Plan. A Primary Care Provider will be auto-assigned by the medical carrier based upon your home address provided to the Trust Administrative Office by your employer. Your dependents will not be added to the Plan until the next Open Enrollment period, and only if the required forms and documentation are timely received by the Trust Administrative Office.

Continuing Eligibility

After you establish Initial Eligibility, you will maintain your eligibility under the Trust, as long as employer contributions continue to be paid on your behalf.

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; 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.
4) Non-payment of Employer Contributions

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 your regular required monthly contribution (if applicable), provided you are eligible 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, you 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 SPD.

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 and 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 Administrative Office. Coverage may be denied if the necessary forms are not received by the Trust Administrative Office within 30 days from the date your dependent becomes eligible.

Eligible Dependents are your:
(1) spouse; (2) Registered Domestic Partner, (3) the Participant's children, including adopted children, and stepchildren, under the age of 26, (4) any other unmarried dependent under the age of 19 entirely supported by the Employee or the Employee's spouse, permanently residing in the Employee's household, and for whom the Employee or Employee's spouse is the court appointed guardian. If you enroll a new Dependent within 30 days of marriage or placement of adoption or guardianship, coverage for your new Dependent will be effective on the first of the month after the date of marriage, placement, or guardianship. If you enroll a newborn Dependent child within 30 days of birth, coverage for your new Dependent will be effective retroactive to the date of birth.

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 19, will continue to qualify as an eligible Dependent 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.

Your spouse will not be covered under this Fund if she is on active duty in any armed forces for more than 31 days unless she has elected to self-pay as described on the previous page under "Military Leave of Absence."

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 Spouse enters into full-time military, naval, or air service, or;
4) In the event of a divorce or legal separation, your spouse's eligibility will terminate when the final decree or order 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 Administrative Office will review the Order to verify that it meets the legal requirements. The Trust Administrative 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 names, date of birth, Social Security number and relationship to the Employee have been provided to the Trust Administrative 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, recuperation, 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 Administrative 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 cov-

erage 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 Qualifying 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 <u>and</u> 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 <u>after</u> the expiration of the 18 month period. To qualify for this additional period of coverage, you must notify the Trust Administrative 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 Administrative 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 Administrative 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 Administrative 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 Administrative 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 Administrative 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.
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 Dependents 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 Anthem Blue Cross, 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 Anthem Blue Cross. 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 Administrative Office at 1-800-753-0222.

California Insurance Marketplace (California Exchange)

In addition to COBRA continuation coverage, there may be other options for you and your family. The California Insurance Marketplace (California Exchange) offers many health plans to choose from. Open enrollments will be held from October 15 through December 7 for coverage effective the following year. After open enrollment ends, you may have special enrollment rights under certain circumstances. More information is available from the California Exchange website at www.coveredca.com. Also, you might be eligible for a tax credit that lowers your monthly premium if you are not eligible for coverage through the Trust.

Note: If you decide to enroll in COBRA coverage and then drop your COBRA coverage, you can only enroll in the Exchange during its open enrollment period (or a special enrollment period should you experience another life event as defined by the Exchange).

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, you may contact HIPP by e-mail at HIPP@dhcs.ca.gov or by fax at 916-440-5676. or visit the website at http://www.dhcs.ca.gov/services/Pages/TPLRD_CAU_cont.aspx .

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 Anthem Blue Cross can be obtained, free of charge on the Trust's website - www.pacfed-must, or by contacting the Trust Administrative Office.

It is important you send the completed enrollment form to the Trust Administrative 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. Remember if you fail to submit a completed enrollment form to the Trust Administrative Office within 30 days from the date you become eligible, you will be automatically enrolled in the Plan and you will be auto-assigned a Primary Care Provider based upon your home address.

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 Administrative Office before incurring any expenses.

Health Maintenance Organization (Anthem Blue Cross)

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.

Anthem Blue Cross 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 Administrative Office.

Open Enrollment Period

You have the option to add or delete dependents 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. 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 Administrative 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 Administrative Office within 30 days from the date you are eligible to change your medical plan. The Trust Administrative Office can provide you with information regarding the medical benefits provided by Anthem Blue Cross.

If you move, or are no longer in the service area of the HMO, you should notify the Trust Administrative Office. Further information concerning the Trust's Open Enrollment Period will be mailed by the Trust Administrative 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 if a cesarean), the group health plan must cover a post-discharge visit for the mother and newborn within 48 hours of discharge when prescribed 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)

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.

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) 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
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 Administrative 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 amounts of your claims exceed a certain amount, the Trust may disclose information about your claims to our stop-loss insurance carrier.

<u>**Health Care Operations**</u>: 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
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 Administrative 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.

Mental Health

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.

Under federal and state mental health and substance abuse parity laws, a plan is required to cover services for conditions found in the Diagnostic and Statistical Manual of Mental Disorders (unless an exclusion applies as allowed by state statute). The Plan must make a determination of services and treatment as they would for any medical condition. For any mental health condition, the decision must be based on whether the treatment is medically necessary under the terms of the policy and appropriate for the individual. This is inclusive of diagnosis and treatment for the following serious mental illnesses and emotional disturbances. These include but are not limited to: 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 (DSM) of Mental Health.

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 Administrative 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 Anthem Blue Cross, 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 Evidence of Coverage booklet or contact the Provider directly. You may obtain an Evidence of Coverage booklet free of charge from the Trust Administrative Office.

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

Your Claim Regarding Eligibility must be approved or denied by the Trust Administrative 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 Administrative 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 Administrative 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 Administrative Office will be happy to assist you in resolving claims issues, please contact the Trust Administrative Office as soon as an issue arises.

PacFed Benefit Administrators
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 Administrative Office who will assist you in explaining your benefits, or may intervene on your behalf with the Provider. **However, you must contact the Trust Administrative 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 Administrative 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.

Limitation to File a Lawsuit

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.

Reviewing a Denied Claim Externally

1) **In General** - You may have the right to appeal any adverse claim decision to an independent third party after completing an "internal" appeal, as described above. An "external" review is handled by an independent review organization (IRO), which is independent from the Plan and is not bound to the Plan's findings, as described in this section.

   External review is available to rescissions of coverage.

   Generally, you must exhaust the internal claims and appeals procedure before an external review is available to you (see below for more details). However, in the event that completing an internal appeal would jeopardize your life, health, or ability to regain maximum function, you are entitled to apply for expedited external review.

   If the IRO reverses the Plan's benefit denial, the Plan must immediately provide coverage and payment for the reversed claim(s).

   There are two types of external review: standard and expedited.

2) **Standard External Review Procedures**

   a. **Dates to Request** - You may request external review within four months of receiving notice that your claim has been denied. In the event that there is no corresponding date four months after the date of such receipt (for example, Feb. 30th), you must file by the first day of the fifth month following receipt of your claim denial.

b. **Initial Determination** - Within five days of receipt of the request, the Plan will make an initial determination whether you are eligible for Plan participation and have provided all the requisite paperwork for the appeal. Within one day after completing the initial determination, the Administrator will notify you of the results. If your request is incomplete, the notice will state why it is incomplete and allow you to correct it within 48 hours or by the end of the four month request period, whichever is later. If you are ineligible for Plan participation, the notice will state the reasons why you are ineligible and provide you contact information for the government agency that regulates plans like this one.

c. **Referral** - If your request is complete, it will be forwarded to an IRO. To combat any bias, the IRO will be one of at least three that the Plan rotates external review requests between, none of which are eligible for any financial incentives from the Plan to support a denial of benefits to you.

d. **Review by IRO** – The Plan's contract with the IROs that it refers requests for external review will provide that:

   i. The IRO will utilize legal experts where appropriate to make coverage determinations under the Plan.

   ii. The IRO will notify you of the request's eligibility and acceptance for review. That notice will inform you that you may submit additional information that the IRO must consider for the review within 10 days of receiving the notice; after 10 days, the IRO is allowed, but not required, to review the information you send it.

   iii. The Plan will send the IRO all the documents and other information it considered for your claim within five days of referring it the IRO. If the Plan fails to provide this information timely, the IRO may reverse the claim denial. If that happens, it will notify you within one day.

   vi. The IRO will consider the documentation and provide a written notice of its determination to you and the Plan within 45 of receiving the referral.

e. **Notice from IRO** – The IRO's notice will contain:

   i. A general description of the request for review and information sufficient to identify the claim (including dates of service, names of healthcare providers, the claim amount (if applicable), diagnosis codes and their corresponding meanings, treatment codes and their corresponding meanings, and the reason for the previous denial),

   ii. The date the IRO received the request for external review and the date of the IRO's decision,

   iii. Reference to specific evidence or documentation considered in reaching its conclusion,

   iv. A discussion of the reason(s) for its decision,

   v. Notification that the determination is binding, except that other remedies may be available to you or the Plan in court, and

   vi. Contact information for the government agency that regulates plans like this one.

3) **Expedited External Review Procedures**

a. **Availability** - The Plan must provide for an expedited review if: (1) the time for a regular external review would seriously jeopardize your life or health or your ability to regain maximum function and you file a request for an expedited review, or (2) your claim involves an admission, availability of care, continued stay or healthcare service for which you received emergency services but have not been discharged from a facility.

b. **Initial Determination** – Immediately after receiving the request, the Plan will make an initial determination whether you are eligible for Plan participation and have provided all the requisite paperwork for the appeal. The Plan must then immediately notify you of the results. If your request is incomplete, the notice will state why it is incomplete and allow you to correct it within 48 hours or by the end of the four month request period, whichever is later. If you are ineligible for Plan participation, the notice will state the reasons why you are ineligible and provide you contact information for the government agency that regulates plans like this one.

c. **Referral** - If your request is complete, it will be expeditiously forwarded to an IRO, along with any documentation regarding your claim.

d. **Review by IRO** – Expedited review by the IRO has the same requirements as standard review, except that it must complete the review and provide its decision as expeditiously as possible, considering your medical needs. The process may not exceed 72 hours for notice in writing, or 48 hours if the notice is not in writing.

e. **Notice from IRO** – The content of the IRO notice must meet the same requirements for as standard review.

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
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.

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 avail-

able for inspection at the Trust Administrative 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.

Michael L. Cox
PacFed Benefit Administrators
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 Administrative 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:

R.M. “Spike” Irwin
Jennifer L. Young
Mike Bergen
Jason Hodge
Sean Harren

Address:

c/o PacFed Benefit Administrators
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

Anthem Blue Cross
P.O. Box 60007
Los Angeles CA 90060-0007

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 Administrative 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 Administrative 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 Administrative Office may make a reasonable charge for the copies.

- Receive a summary of the Plan's annual financial report. The Trust Administrative 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 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.

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 Administrative 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 Administrative 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 Administrative 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 Administrative 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

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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 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 out of network 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**
Out-of-Network Physician Services:	• Office Visits, including out-of-network Specialists (no referral necessary) • Preventive care for children • Minor Surgical Procedures (As defined in #6 of the Limitations & Exclusions section.) • Radiology • Pathology • Diagnostic tests (x-ray, labs) • Imaging (CT/PET scans, MRIs)	80% of charges not to exceed customary and reasonable amount
Out-of-Network Mental/Nervous Disorders and Alcohol/Chemical Dependency	Outpatient services, including: • Psychotherapy & counseling • Treatment of alcoholism & chemical dependency	80% of charges not to exceed customary & reasonable amount

	Covered Expenses	Benefit Reimbursement
Specialized Foot-wear	The Options Rider will cover specialized foot-wear, including foot orthotics, such as custom-made orthopedic shoes or custom molded or-thotics, deemed to be Medically Necessary by a certified orthotist, certified prosthetist, or Medical Doctor for You and your Dependents. However, 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 Anthem Blue Cross. When filing a claim for such specialized foot-wear, you must submit the original bill, indicat-ing that the specialized footwear is Medically Necessary, and the notice from Anthem Blue Cross, declining coverage under its plan of ben-efits.	Up to a maximum of $500 per calendar year or as otherwise authorized by the Trustees towards the cost of the specialized footwear when consid-ered to be Medically Nec-essary.
Additional Ser-vices	• Out-of-network Chiropractic • Out-of-network acupuncture services (including for dietary control when rec-ommended by a licensed medical pro-vider) • Out-of-network Podiatric Services	80% of charges not to ex-ceed customary and rea-sonable amount

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, specialized footwear or any other services that are not Medi-cally Necessary.
3. Charges for benefits that are covered by your HMO benefit plans (currently Anthem Blue-Cross and MHN)
4. Charges for copayments, deductibles and/or coinsurance paid under your HMO benefit plan.
5. Charges for inpatient hospital services and for any other type of facility charges. Emergency room charges are not covered.
6. Charges for maternity care in any setting.
7. 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.

8. Charges for adult physical examinations.
9. 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.
10. 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.
11. 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.
12. Charges for care, treatment, services or supplies that are primarily for dietary control (except for out-of-network acupuncture services when recommended by a licensed medical provider), including but not limited to any exercise programs:
    a) whether formal or informal, and
    b) whether or not recommended by a physician
13. Charges for dental work.
14. Charges for treatment of Temporomandibular Joint Syndrome ('TMJ").
15. Charges for testing, training, or rehabilitation for educational, developmental or vocational purposes.
16. Charges for treatment of a learning disability.
17. 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.

18. Charges incurred for home health care or hospice care.
19. Charges incurred for care or treatment of an intentionally self-inflicted injury.
20. Charges incurred for treatment with fertility drugs or artificial insemination and in-vitro fertilization including development and implantation of an embryo developed in-vitro).
21. Charges for telephone consultations.
22. Charges for in-network acupuncture.
23. 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.
24. Charges for which a Covered Person is entitled to payment under any local, state or federal Governmental agency including Medicare, but not MediCal.
25. 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.
26. Charges that in the absence of insurance would not be made; or charges for which there is no legal obligation to pay.
27. 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.
28. Charges for injury or sickness resulting from any act of war, even if war has not been declared.
29. Charges resulting from non-therapeutic release of nuclear energy.
30. 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.

Your summary of benefits

Anthem Blue Cross

Your Plan: Premier HMO 10/100% - MUST Trust

Your Network: California Care HMO

This summary of benefits is a brief outline of coverage, designed to help you with the selection process. This summary does not reflect each and every benefit, exclusion and limitation which may apply to the coverage. For more details, important limitations and exclusions, please review the formal Evidence of Coverage (EOC). If there is a difference between this summary and the Evidence of Coverage (EOC), the Evidence of Coverage (EOC), will prevail.

Anthem Blue Cross HMO benefits are covered only when services are provided or coordinated by the primary care physician and authorized by the participating medical group or independent practice association (IPA); except OB/GYN services received within the member's medical group/IPA, and services for mental and nervous disorders and substance abuse. Benefits are subject to all terms, conditions, limitations, and exclusions of the EOC.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Overall Deductible *See notes section to understand how your deductible works. Your plan may also have a separate Prescription Drug Deductible. See Prescription Drug Coverage section.*	$0	$0
Out-of-Pocket Limit *When you meet your out-of-pocket limit, you will no longer have to pay cost-shares during the remainder of your benefit period. See notes section for additional information regarding your out of pocket maximum.*	$2,000 single / $6,000 family	$0 single / $0 family
Preventive care/screening/immunization *In-network preventive care is not subject to deductible, if your plan has a deductible.*	No charge	Not covered
Doctor Home and Office Services		
Primary care visit to treat an injury or illness	$10 copay per visit	Not covered
Specialist care visit	$10 copay per visit	Not covered
Prenatal and Post-natal Care	$10 copay per visit	Not covered
Other practitioner visits: Retail health clinic	Not covered	Not covered

Anthem Blue Cross is the trade name of Blue Cross of California. Independent licensee of the Blue Cross Association. ® ANTHEM is a registered trademark of Anthem Insurance Companies, Inc. The Blue Cross name and symbol are registered marks of the Blue Cross Association.

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
On-line Visit	Not covered	Not covered
Chiropractor services *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Chiropractor visits count towards your physical and occupational therapy limit.*	$10 copay per visit	Not covered
Acupuncture	$10 copay per visit	Not covered
Other services in an office:		
Allergy testing	$10 copay per visit	Not covered
Chemo/radiation therapy	No copay	Not covered
Hemodialysis	No copay	Not covered
Prescription drugs *For the drugs itself dispensed in the office thru infusion/injection*	$50 copay	Not covered
Diagnostic Services		
Lab:		
Office	No charge	Not covered
Freestanding Lab	No charge	Not covered
Outpatient Hospital	No charge	Not covered
X-ray:		
Office	No charge	Not covered
Freestanding Radiology Center	No charge	Not covered
Outpatient Hospital	No charge	Not covered
Advanced diagnostic imaging (for example, MRI/PET/CAT scans):		
Office *Costs may vary by site of service.*	No copay	Not covered
Freestanding Radiology Center *Costs may vary by site of service.*	No copay	Not covered
Outpatient Hospital *Costs may vary by site of service.*	No copay	Not covered

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Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Emergency and Urgent Care		
Emergency room facility services *This is for the hospital/facility charge only. The ER physician charge may be separate. Copay waived if admitted.*	$100 copay per visit	Covered as In-Network
Emergency room doctor and other services	No charge	Covered as In-Network
Ambulance (air and ground)	$100 copay per trip for ground and air	Covered as In-Network
Urgent Care (office setting) *Copay waived if admitted. Costs may vary by site of service.*	$10 copay per visit	$50 copay per visit
Mental Health – *Carved out request with eCEM – Requet ID CA89228*	.	
Outpatient Surgery		
Facility fees:		
Hospital	$50/admit	Not covered
Freestanding Surgical Center	$50/admit	Not covered
Doctor and other services	No charge	Not covered
Hospital Stay (all inpatient stays including maternity)		
Facility fees (for example, room & board)	$100/admit	Not covered
Doctor and other services	No charge	Not covered
Recovery & Rehabilitation		
Home health care *Coverage for In-Network Provider is limited to 100 visit limit per benefit period.*	No charge	Not covered

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Your summary of benefits

Covered Medical Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Rehabilitation services (for example, physical/speech/occupational therapy):		
Office *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service. Chiropractor visits count towards your physical and occupational therapy limit.*	$10 copay per visit	Not covered
Outpatient hospital *Coverage for In-Network Provider is limited to 60 day limit per benefit period for Physical, Occupational and Speech Therapy combined. Costs may vary by site of service.*	$10 copay per visit	Not covered
Habilitation services *Habilitation and Rehabilitation visits count towards your Rehabilitation limit.*	$10 copay per visit	Not covered
Cardiac rehabilitation		
Office	$10 copay per visit	Not covered
Outpatient hospital	$10 copay per visit	Not covered
Skilled nursing care (in a facility) *Coverage for In-Network Provider is limited to 100 day limit per benefit period.*	$100/admit	Not covered
Hospice	No charge	Not covered
Durable Medical Equipment	No copay	Not covered
Prosthetic Devices	No charge	Not covered

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Your summary of benefits

Covered Prescription Drug Benefits	Cost if you use an In-Network Provider	Cost if you use a Non-Network Provider
Pharmacy Deductible	$0	$0
Pharmacy Out of Pocket	Combined with medical out of pocket	Combined with medical out of pocket
Prescription Drug Coverage *This plan uses an Essential formulary List. Drugs not on the list are not covered.*		
Tier1 - Typically Generic *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) This plan uses an Essential Formulary drug list. You pay additional copays or coinsurance on all tiers for retail fills that exceed 30 days. Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 1 - Typically Lower Cost Generic $10 copay per prescription (retail only) and $10 copay per prescription (home delivery only)	Tier $10 copay plus 50% (retail only)
Tier2 - Typically Preferred / Brand *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 2- Typically Preferred Brand & non-preferred generic drugs $25 copay per prescription (retail only) and $50 copay per prescription (home delivery only).	Tier 2- $25 copay plus 50% coinsurance (retail only).
Tier3 - Typically Non-Preferred / Specialty Drugs *Covers up to a 30 day supply (retail pharmacy) Covers up to a 90 day supply (home delivery program) Member pays the retail pharmacy copay plus 50% for out of network.*	Tier 3-Typically Non-Preferred Brand and generic drugs $35 copay per prescription (retail only) and $70 copay per prescription (home delivery).	Tier 3 -$35 copay plus 50% coinsurance (retail only).

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Your summary of benefits

Notes:

- This Summary of Benefits has been updated to comply with federal and state requirements, including applicable provisions of the recently enacted federal health care reform laws. As we receive additional guidance and clarification on the new health care reform laws from the U.S. Department of Health and Human Services, Department of Labor and Internal Revenue Service, we may be required to make additional changes to this Summary of Benefits. This Summary of Benefits, as updated, is subject to the approval of the California Department of Insurance and the California Department of Managed Health Care (as applicable).
- In addition to the benefits described in this summary, coverage may include additional benefits, depending upon the member's home state. The benefits provided in this summary are subject to federal and California laws. There are some states that require more generous benefits be provided to their residents, even if the master policy was not issued in their state. If the member's state has such requirements, we will adjust the benefits to meet the requirements.
- Your plan requires a selection of a Primary Care Physician. Your plan requires a referral from your Primary Care Physician for select covered services.
- Preventive Care Services includes physical exam, preventive screenings (including screenings for cancer, HPV, diabetes, cholesterol, blood pressure, hearing and vision, immunization, health education, intervention services, HIV testing) and additional preventive care for women provided for in the guidance supported by Health Resources and Service Administration.
- For Medical Emergency care rendered by a Non-Participating Provider or Non-Contracting Hospital, reimbursement is based on the reasonable and customary value. Members may be responsible for any amount in excess of the reasonable and customary value.
- If your plan includes an emergency room facility copay and you are directly admitted to a hospital, your emergency room facility copay is waived.
- Certain services are subject to the utilization review program. Before scheduling services, the member must make sure utilization review is obtained. If utilization review is not obtained, benefits may be reduced or not paid, according to the plan.
- Additional visits maybe authorized if medically necessary. Pre-service review must be obtained prior to receiving the additional services.
- Skilled Nursing Facility day limit does not apply to mental health and substance abuse.
- Respite Care limited to 5 consecutive days per admission.
- Freestanding Lab and Radiology Center is defined as services received in a non-hospital based facility.
- Infertility services are not included in the out of pocket amount.
- Coordination of Benefits: The benefits of this plan may be reduced if the member has any other group health or dental coverage so that the services received from all group coverage do not exceed 100% of the covered expense
- When using non-network pharmacy; members are responsible for in-network pharmacy copay plus 50% of the remaining prescription drug maximum allowed amount & costs in excess of the prescription drug maximum allowed amount. Members will pay upfront and submit a claim form.
- Certain drugs require pre-authorization approval to obtain coverage.
- Supply limits for certain drugs may be different, go to Anthem website or call customer service.
- For additional information on limitations and exclusions and other disclosure items that apply to this plan, go to https://le.anthem.com/pdf?x=CA_LG_HMO
- For additional information on this plan, please visit sbc.anthem.com to obtain a Summary of Benefit Coverage.

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Benefit Chart

GROUP/PLAN NAME:	**Multi - Union Security Trust Fund**
ACCOUNT #:	**008836**
PLAN CODE:	**018**
EFFECTIVE DATE:	**11/1/2003 / rev 2/1/2014**
MHPAEA COMPLIANT:	**Yes**
AB88 COMPLIANT:	**Yes**

BENEFITS	**In Network**	**Out of Network**
Deductible (combined for medical and mental health/chemical dependency plan)		
For each member	**N/A**	**N/A**
For each family	**N/A**	**N/A**
Out-of-Pocket Maximum (combined for medical and mental health/chemical dependency plan)		
For each member	**$2,000.00**	**N/A**
For each family	**$6,000.00**	**N/A**
Emergency Services in an Emergency Room (mental health/chemical dependency treatment)		
Emergency Room Professional	**$0**	
Emergency Room Facility	**$0**	
Ambulance Cost Share	**$0**	
Laboratory Services (mental health/chemical dependency treatment)		
Laboratory services	**$0**	
Participating Practitioner Visits to Home (mental health/chemical dependency treatment)		
Participating Practitioner Visits to Home (Any number of visits in one day treated as one visit)	**$0**	**N/A**
Severe Mental Illnesses		
Outpatient		
Outpatient consultation	**$0**	**N/A**
Group therapy session	**$0**	**N/A**
Maximum visits per calendar year	**Unlimited**	**N/A**
Inpatient		
Inpatient care in a hospital, excluding residential treatment centers	**$0 Per Day**	**N/A**
Residential treatment centers	**$0 Per Day**	**N/A**
Maximum days per calendar year	**Unlimited**	**N/A**
Inpatient physician visits	**$0**	**N/A**

Alternate Care		
Partial Hospitalization/Day Treatment/Intensive Outpatient Program	**$0 Per Day**	**N/A**
Maximum days per calendar year	**Unlimited**	**N/A**
Other Mental Illnesses		
Outpatient		
Outpatient consultation	**$0**	**N/A**
Group therapy session	**$0**	**N/A**
Maximum visits per calendar year	**Unlimited**	**N/A**
Inpatient		
Inpatient care in a hospital, excluding residential treatment centers	**$0 Per Day**	**N/A_**
Residential treatment centers	**$0 Per Day**	**N/A**
Maximum days per calendar year (combined with Other Mental Illness Alternate Care)	**Unlimited**	**N/A**
Inpatient physician visits	**$0**	**N/A**
Alternate Care		
Partial Hospitalization/Day Treatment/Intensive Outpatient Program	**$0 Per Day**	**N/A**
Maximum days per calendar year (combined with Other Mental Illness Inpatient)	**Unlimited**	**N/A**
Chemical Dependency Rehabilitation		
Outpatient		
Outpatient consultation	**$0**	**N/A**
Group therapy session	**$0**	**N/A**
Maximum visits per calendar year	**Unlimited**	**N/A**
Inpatient		
Inpatient care in a hospital, excluding residential treatment centers	**$0 Per Day**	**N/A**
Residential treatment centers	**$0 Per Day**	**N/A**
Maximum days per calendar year	**Unlimited**	**N/A**
Inpatient physician visits	**$0**	**N/A**
Alternate Care		
Partial Hospitalization/Day Treatment/Intensive Outpatient Program	**$0 Per Day**	**N/A**
Maximum days per calendar year	**Unlimited**	**N/A**
Detoxification		
Outpatient		
Outpatient Consultation	**$0**	**N/A**

Inpatient		
Inpatient care in a hospital, excluding residential treatment centers	**$0 Per Day**	**N/A**
Maximum days per calendar year	**Unlimited**	**N/A**

Prior Authorization:
Prior Authorization Required - Yes
Prior Auth In Patient Penalty - 100%

Dental Health Services

Schedule of Covered Services and Copayments
Must Trust

Code	Description	Copayment
D9543	Office Visit	0
D9986	missed appointment	Per office policy
D9987	cancelled appointment	Per office policy

Diagnostic

Code	Description	Copayment
D0120	periodic oral evaluation - established patient	0
D0140	limited oral evaluation - problem focused	0
D0145	oral evaluation for a patient under three years of age and counseling with primary caregiver	0
D0150	comprehensive oral evaluation - new or established patient	0
D0160	detailed and extensive oral evaluation - problem focused, by report	0
D0170	re-evaluation - limited, problem focused (established patient; not post-operative visit)	0
D0171	re-evaluation – post-operative office visit	0
D0180	comprehensive periodontal evaluation - new or established patient	0
D0210	intraoral - complete series of radiographic images	0
D0220	intraoral - periapical first radiographic image	0
D0230	intraoral - periapical each additional radiographic image	0
D0240	intraoral - occlusal radiographic image	0
D0250	extra-oral – 2D projection radiographic image created using a stationary radiation source, and detector	0
D0270	bitewing - single radiographic image	0
D0272	bitewings - two radiographic images	0
D0273	bitewings - three radiographic images	0
D0274	bitewings - four radiographic images	0
D0277	vertical bitewings - 7 to 8 radiographic images	0
D0330	panoramic radiographic image	0
D0340	2D cephalometric radiographic image – acquisition, measurement and analysis	10
D0350	2D oral/facial photographic image obtained intra-orally or extra-orally	0
D0391	interpretation of diagnostic image by a practitioner not associated with capture of the image, including report	5
D0415	collection of microorganisms for culture and sensitivity	0
D0425	caries susceptibility tests	0
D0431	adjunctive pre-diagnostic test that aids in detection of mucosal abnormalities including premalignant and malignant lesions, not to include cytology or biopsy procedures	5
D0460	pulp vitality tests	0
D0470	diagnostic casts	5
D0601	caries risk assessment and documentation, with a finding of low risk	0
D0602	caries risk assessment and documentation, with a finding of moderate risk	0
D0603	caries risk assessment and documentation, with a finding of high risk	0

Preventive

Code	Description	Copayment
D1110	Prophylaxis - adult	0
D1120	Prophylaxis - child	0
D1206	topical application of fluoride varnish	10
D1208	topical application of fluoride – excluding varnish	0
D1310	nutritional counseling for control of dental disease	0
D1320	tobacco counseling for the control and prevention of oral disease	0
D1330	oral hygiene instructions	0
D1351	sealant - per tooth	0
D1353	sealant repair – per tooth	0

Space Maintainers

Code	Description	Copayment
D1510	space maintainer - fixed - unilateral	12
D1515	space maintainer - fixed - bilateral	24
D1520	space maintainer - removable - unilateral	12
D1525	space maintainer - removable - bilateral	12
D1550	re-cement or re-bond space maintainer	0
D1555	removal of fixed space maintainer	0
D1575	distal shoe space maintainer – fixed – unilateral	12

Amalgam Restorations - Primary or Permanent

Code	Description	Copayment
D2140	amalgam - one surface, primary or permanent	0
D2150	amalgam - two surfaces, primary or permanent	0
D2160	amalgam - three surfaces, primary or permanent	0
D2161	amalgam - four or more surfaces, primary or permanent	0

Resin-Based Composite Restorations

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Code		Description	Copayment
D2330		resin-based composite - one surface, anterior	0
D2331		resin-based composite - two surfaces, anterior	0
D2332		resin-based composite - three surfaces, anterior	0
D2335		resin-based composite - four or more surfaces or involving incisal angle (anterior)	0
D2390		resin-based composite crown, anterior	30
D2391		resin-based composite - one surface, posterior	30
D2392		resin-based composite - two surfaces, posterior	50
D2393		resin-based composite - three surfaces, posterior	70
D2394		resin-based composite - four or more surfaces, posterior	90

Crowns - Single Restoration Only

**Copayments include charges for noble metal and high noble metal/titanium. D27SC is an optional upgrade charge added to the standard base crown copayment for specialized porcelain such as Lava, Captek, Cercon, Impress, Emax, etc. and D27BM is an optional benefit for porcelain butt margin. D27ML is an additional copayment for porcelain crowns on molar teeth. Cosmetic-only porcelain crowns/PFM for $580, plus applicable metal upgrade costs, for a maximum of 6 teeth every 5 years.*

Code		Description	Copayment
D2510		inlay - metallic - one surface	35
D2520		inlay - metallic - two surfaces	35
D2530		inlay - metallic - three or more surfaces	35
D2542		onlay - metallic - two surfaces	35
D2543		onlay - metallic - three surfaces	35
D2544		onlay - metallic - four or more surfaces	35
D2610		inlay - porcelain/ceramic - one surface	35
D2620		inlay - porcelain/ceramic - two surfaces	35
D2630		inlay - porcelain/ceramic - three or more surfaces	35
D2642		onlay - porcelain/ceramic - two surfaces	35
D2643		onlay - porcelain/ceramic - three surfaces	35
D2644		onlay - porcelain/ceramic - four or more surfaces	35
D2650		inlay - resin-based composite - one surface	35
D2651		inlay - resin-based composite - two surfaces	35
D2652		inlay - resin-based composite - three or more surfaces	35
D2662		onlay - resin-based composite - two surfaces	35
D2663		onlay - resin-based composite - three surfaces	35
D2664		onlay - resin-based composite - four or more surfaces	35
D2710		crown - resin-based composite (indirect)	35
D2712		crown - ¾ resin-based composite (indirect)	35
D2720	*	crown - resin with high noble metal	130
D2721		crown - resin with predominantly base metal	50
D2722	*	crown - resin with noble metal	100
D2740		crown - porcelain/ceramic substrate	50
D2750	*	crown - porcelain fused to high noble metal	130
D2751		crown - porcelain fused to predominantly base metal	50
D2752	*	crown - porcelain fused to noble metal	100
D2780	*	crown - 3/4 cast high noble metal	130
D2781		crown - 3/4 cast predominantly base metal	50
D2782	*	crown - 3/4 cast noble metal	100
D2783		crown - 3/4 porcelain/ceramic	100
D2790	*	crown - full cast high noble metal	130
D2791		crown - full cast predominantly base metal	50
D2792	*	crown - full cast noble metal	100
D2794	*	crown - titanium	130
D2799		provisional crown– further treatment or completion of diagnosis necessary prior to final impression	200
D27BM		crown-butt margin	50
D27ML		crown- porcelain on molar	100
D27SC		crown- specialty upgrade	200

Other Restorative Services

Code	Description	Copayment
D2910	re-cement or re-bond inlay, onlay, veneer or partial coverage restoration	0
D2915	re-cement or re-bond indirectly fabricated or prefabricated post and core	0
D2920	re-cement or re-bond crown	0
D2921	reattachment of tooth fragment, incisal edge or cusp	0
D2929	prefabricated porcelain/ceramic crown – primary tooth	10
D2930	prefabricated stainless steel crown - primary tooth	10
D2931	prefabricated stainless steel crown - permanent tooth	10
D2932	prefabricated resin crown	10
D2933	prefabricated stainless steel crown with resin window	30
D2934	prefabricated esthetic coated stainless steel crown - primary tooth	30
D2940	protective restoration	0
D2941	interim therapeutic restoration – primary dentition	0
D2949	restorative foundation for an indirect restoration	0
D2950	core buildup, including any pins when required	0
D2951	pin retention - per tooth, in addition to restoration	0
D2952	post and core in addition to crown, indirectly fabricated	0
D2953	each additional indirectly fabricated post - same tooth	0
D2954	prefabricated post and core in addition to crown	0
D2955	post removal	55
D2957	each additional prefabricated post - same tooth	0

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Code	Description	Copayment
D2960	labial veneer (resin laminate) - chairside	35
D2961	labial veneer (resin laminate) - laboratory	50
D2962	labial veneer (porcelain laminate) - laboratory	50
D2971	additional procedures to construct new crown under existing partial denture framework	25
D2975	coping	50
D2990	resin infiltration of incipient smooth surface lesions	0

Endodontics

Code	Description	Copayment
D3110	pulp cap - direct (excluding final restoration)	0
D3120	pulp cap - indirect (excluding final restoration)	0
D3220	therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament	0
D3221	pulpal debridement, primary and permanent teeth	0
D3222	partial pulpotomy for apexogenesis - permanent tooth with incomplete root development	0
D3230	pulpal therapy (resorbable filling) - anterior, primary tooth (excluding final restoration)	20
D3240	pulpal therapy (resorbable filling) - posterior, primary tooth (excluding final restoration)	20
D3310	endodontic therapy, anterior tooth (excluding final restoration)	20
D3320	endodontic therapy, bicuspid tooth (excluding final restoration)	20
D3330	endodontic therapy, molar (excluding final restoration)	20
D3331	treatment of root canal obstruction; non-surgical access	20
D3332	incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	20
D3333	internal root repair of perforation defects	20
D3346	retreatment of previous root canal therapy - anterior	70
D3347	retreatment of previous root canal therapy - bicuspid	120
D3348	retreatment of previous root canal therapy - molar	170
D3351	apexification/recalcification – initial visit (apical closure / calcific repair of perforations, root resorption, etc.)	0
D3352	apexification/recalcification – interim medication replacement	0
D3353	apexification/recalcification - final visit (includes completed root canal therapy - apical closure/calcific repair of perforations, root resorption, etc.)	0
D3355	pulpal regeneration - initial visit	0
D3356	pulpal regeneration - interim medication replacement	0
D3357	pulpal regeneration - completion of treatment	20
D3410	apicoectomy - anterior	20
D3421	apicoectomy - bicuspid (first root)	20
D3425	apicoectomy - molar (first root)	20
D3426	apicoectomy (each additional root)	20
D3427	periradicular surgery without apicoectomy	20
D3430	retrograde filling - per root	0
D3920	hemisection (including any root removal), not including root canal therapy	0
D3950	canal preparation and fitting of preformed dowel or post	0

Periodontics

Code	Description	Copayment
D4210	gingivectomy or gingivoplasty - four or more contiguous teeth or tooth bounded spaces per quadrant	25
D4211	gingivectomy or gingivoplasty - one to three contiguous teeth or tooth bounded spaces per quadrant	0
D4212	gingivectomy or gingivoplasty to allow access for restorative procedure, per tooth	0
D4230	anatomical crown exposure - four or more contiguous teeth per quadrant	300
D4231	anatomical crown exposure - one to three teeth per quadrant	200
D4240	gingival flap procedure, including root planing - four or more contiguous teeth or tooth bounded spaces per quadrant	300
D4241	gingival flap procedure, including root planing - one to three contiguous teeth or tooth bounded spaces per quadrant	200
D4245	apically positioned flap	200
D4249	clinical crown lengthening – hard tissue	200
D4260	osseous surgery (including elevation of a full thickness flap and closure) – four or more contiguous teeth or tooth bounded spaces per quadrant	300
D4261	osseous surgery (including elevation of a full thickness flap and closure) – one to three contiguous teeth or tooth bounded spaces per quadrant	200
D4263	bone replacement graft – retained natural tooth – first site in quadrant	195
D4264	bone replacement graft – retained natural tooth – each additional site in quadrant	60
D4266	guided tissue regeneration - resorbable barrier, per site	230
D4267	guided tissue regeneration - nonresorbable barrier, per site (includes membrane removal)	225
D4268	surgical revision procedure, per tooth	435
D4270	pedicle soft tissue graft procedure	445

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Code	Description	Copayment
D4274	mesial/distal wedge procedure, single tooth (when not performed in conjunction with surgical procedures in the same anatomical area)	300
D4277	free soft tissue graft procedure (including recipient and donor surgical sites) first tooth, implant or edentulous tooth position in graft	275
D4278	free soft tissue graft procedure (including recipient and donor surgical sites) each additional contiguous tooth, implant or edentulous tooth position in same graft site	100
D4341	periodontal scaling and root planing - four or more teeth per quadrant	0
D4342	periodontal scaling and root planing - one to three teeth per quadrant	0
D4346	scaling in presence of generalized moderate or severe gingival inflammation – full mouth, after oral evaluation	0
D4355	full mouth debridement to enable comprehensive evaluation and diagnosis	0
D4381	localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth	50
D4910	Periodontal maintenance	0
D4921	gingival irrigation – per quadrant	25
D4999	unspecified periodontal procedure, by report	0

Dentures

Dentures and partials include four months free adjustments.

Code	Description	Copayment
D5110	complete denture - maxillary	65
D5120	complete denture - mandibular	65
D5130	immediate denture - maxillary	65
D5140	immediate denture - mandibular	75
D5211	maxillary partial denture - resin base (including any conventional clasps, rests and teeth)	75
D5212	mandibular partial denture - resin base (including any conventional clasps, rests and teeth)	75
D5213	maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	75
D5214	mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	75
D5221	immediate maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	115
D5222	immediate mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	115
D5223	immediate maxillary partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	115
D5224	immediate mandibular partial denture – cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)	115
D5225	maxillary partial denture - flexible base (including any clasps, rests and teeth)	275
D5226	mandibular partial denture - flexible base (including any clasps, rests and teeth)	275
D5281	removable unilateral partial denture - one piece cast metal (including clasps and teeth)	50

Denture Adjustments & Repairs

Code	Description	Copayment
D5410	adjust complete denture - maxillary	0
D5411	adjust complete denture - mandibular	0
D5421	adjust partial denture - maxillary	0
D5422	adjust partial denture - mandibular	0
D5510	repair broken complete denture base	5
D5520	replace missing or broken teeth - complete denture (each tooth)	5
D5610	repair resin denture base	5
D5620	repair cast framework	5
D5630	repair or replace broken clasp - per tooth	0
D5640	replace broken teeth - per tooth	5
D5650	add tooth to existing partial denture	5
D5660	add clasp to existing partial denture - per tooth	5
D5670	replace all teeth and acrylic on cast metal framework (maxillary)	145
D5671	replace all teeth and acrylic on cast metal framework (mandibular)	145
D5710	rebase complete maxillary denture	0
D5711	rebase complete mandibular denture	0
D5720	rebase maxillary partial denture	0
D5721	rebase mandibular partial denture	0
D5730	reline complete maxillary denture (chairside)	10
D5731	reline complete mandibular denture (chairside)	10
D5740	reline maxillary partial denture (chairside)	10
D5741	reline mandibular partial denture (chairside)	10
D5750	reline complete maxillary denture (laboratory)	10
D5751	reline complete mandibular denture (laboratory)	10
D5760	reline maxillary partial denture (laboratory)	10
D5761	reline mandibular partial denture (laboratory)	10
D5810	interim complete denture (maxillary)	45
D5811	interim complete denture (mandibular)	45
D5820	interim partial denture (maxillary)	45
D5821	interim partial denture (mandibular)	45
D5850	tissue conditioning, maxillary	20
D5851	tissue conditioning, mandibular	20
D5863	overdenture – complete maxillary	270
D5864	overdenture – partial maxillary	270

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Code		Description	Copayment
D5865		overdenture – complete mandibular	270
D5866		overdenture – partial mandibular	270

Implants

**Copayments include charges for noble metal and high noble metal/titanium. Implant services are covered only when performed by a participating general dentist.*

Code		Description	Copayment
D6010		surgical placement of implant body: endosteal implant	1500
D6011		second stage implant surgery	200
D6051		interim abutment	200
D6052		semi-precision attachment abutment	200
D6056		prefabricated abutment – includes modification and placement	450
D6057		custom fabricated abutment – includes placement	450
D6058		abutment supported porcelain/ceramic crown	1000
D6059	*	abutment supported porcelain fused to metal crown (high noble metal)	1080
D6060		abutment supported porcelain fused to metal crown (predominantly base metal)	1000
D6061	*	abutment supported porcelain fused to metal crown (noble metal)	1050
D6062	*	abutment supported cast metal crown (high noble metal)	1080
D6063		abutment supported cast metal crown (predominantly base metal)	1000
D6064	*	abutment supported cast metal crown (noble metal)	1050
D6065		implant supported porcelain/ceramic crown	1000
D6066	*	implant supported porcelain fused to metal crown (titanium, titanium alloy, high noble metal)	1080
D6067	*	implant supported metal crown (titanium, titanium alloy, high noble metal)	1080
D6068		abutment supported retainer for porcelain/ceramic FPD	1000
D6069	*	abutment supported retainer for porcelain fused to metal FPD (high noble metal)	1080
D6070		abutment supported retainer for porcelain fused to metal FPD (predominantly base metal)	1000
D6071	*	abutment supported retainer for porcelain fused to metal FPD (noble metal)	1050
D6072	*	abutment supported retainer for cast metal FPD (high noble metal)	1080
D6073		abutment supported retainer for cast metal FPD (predominantly base metal)	1000
D6074	*	abutment supported retainer for cast metal FPD (noble metal)	1050
D6075		implant supported retainer for ceramic FPD	1000
D6076	*	implant supported retainer for porcelain fused to metal FPD (titanium, titanium alloy, or high noble metal)	1080
D6077	*	implant supported retainer for cast metal FPD (titanium, titanium alloy, or high noble metal)	1080
D6081		scaling and debridement in the presence of inflammation or mucositis of a single implant, including cleaning of the implant surfaces, without flap entry and closure	0
D6085		provisional implant crown	200
D6092		re-cement or re-bond implant/abutment supported crown	30
D6093		re-cement or re-bond implant/abutment supported fixed partial denture	40
D6094	*	abutment supported crown - (titanium)	580
D6104		bone graft at time of implant placement	195
D6110		implant /abutment supported removable denture for edentulous arch – maxillary	2300
D6111		implant /abutment supported removable denture for edentulous arch – mandibular	2300
D6112		implant /abutment supported removable denture for partially edentulous arch – maxillary	25
D6113		implant /abutment supported removable denture for partially edentulous arch – mandibular	25
D6194	*	abutment supported retainer crown for FPD (titanium)	580

Bridges

**Copayments include charges for noble metal and high noble metal/titanium. D62SC and D67SC are optional upgrade charges added to the standard base crown/pontic copayment for specialized porcelain such as Lava, Captek, Cercon, Impress, Emax, etc. and D67BM is an optional benefit for porcelain butt margin. D62ML and D67ML are additional copayments for porcelain on molar teeth. Cosmetic-only porcelain crowns/PFM for $580, plus applicable metal upgrade costs, for a maximum of 6 teeth every 5 years.*

Code		Description	Copayment
D6205		pontic - indirect resin based composite	45
D6210	*	pontic - cast high noble metal	125
D6211		pontic - cast predominantly base metal	45
D6212	*	pontic - cast noble metal	95
D6214	*	pontic - titanium	125
D6240	*	pontic - porcelain fused to high noble metal	125
D6241		pontic - porcelain fused to predominantly base metal	45
D6242	*	pontic - porcelain fused to noble metal	95
D6245		pontic - porcelain/ceramic	50
D6250	*	pontic - resin with high noble metal	125
D6251		pontic - resin with predominantly base metal	45
D6252	*	pontic - resin with noble metal	95
D6253		provisional pontic - further treatment or completion of diagnosis necessary prior to final impression	200
D62ML		pontic- porcelain on molar	100
D62SC		pontic - specialty upgrade	200
D6545		retainer - cast metal for resin bonded fixed prosthesis	45

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Code		Description	Copayment
D6548		retainer - porcelain/ceramic for resin bonded fixed prosthesis	50
D6549		resin retainer – for resin bonded fixed prosthesis	45
D6600		inlay - porcelain/ceramic, two surfaces	50
D6601		retainer inlay - porcelain/ceramic, three or more surfaces	50
D6602	*	retainer inlay - cast high noble metal, two surfaces	115
D6603	*	retainer inlay - cast high noble metal, three or more surfaces	115
D6604		retainer inlay - cast predominantly base metal, two surfaces	35
D6605		retainer inlay - cast predominantly base metal, three or more surfaces	35
D6606	*	retainer inlay - cast noble metal, two surfaces	85
D6607	*	retainer inlay - cast noble metal, three or more surfaces	85
D6608		retainer onlay - porcelain/ceramic, two surfaces	50
D6609		retainer onlay - porcelain/ceramic, three or more surfaces	50
D6610	*	retainer onlay - cast high noble metal, two surfaces	115
D6611	*	retainer onlay - cast high noble metal, three or more surfaces	115
D6612		retainer onlay - cast predominantly base metal, two surfaces	35
D6613		retainer onlay - cast predominantly base metal, three or more surfaces	35
D6614	*	retainer onlay - cast noble metal, two surfaces	85
D6615	*	retainer onlay - cast noble metal, three or more surfaces	85
D6624	*	retainer inlay - titanium	125
D6634	*	retainer onlay - titanium	125
D6710		retainer crown - indirect resin based composite	35
D6720	*	retainer crown - resin with high noble metal	115
D6721		retainer crown - resin with predominantly base metal	35
D6722	*	retainer crown - resin with noble metal	85
D6740		retainer crown - porcelain/ceramic	50
D6750	*	retainer crown - porcelain fused to high noble metal	130
D6751		retainer crown - porcelain fused to predominantly base metal	50
D6752	*	retainer crown - porcelain fused to noble metal	100
D6780	*	retainer crown - 3/4 cast high noble metal	130
D6781		retainer crown - 3/4 cast predominantly base metal	50
D6782	*	retainer crown - 3/4 cast noble metal	100
D6783		retainer crown - 3/4 porcelain/ceramic	100
D6790	*	retainer crown - full cast high noble metal	130
D6791		retainer crown - full cast predominantly base metal	50
D6792	*	retainer crown - full cast noble metal	100
D6793		provisional retainer crown - further treatment or completion of diagnosis necessary prior to final impression	200
D6794	*	retainer crown - titanium	125
D67BM		abutment crown- butt margin	50
D67ML		abutment crown-porcelain on molar	100
D67SC		abutment crown- specialty upgrade	200
D6930		re-cement or re-bond fixed partial denture	0

Oral Surgery

Code		Description	Copayment
D7111		extraction, coronal remnants - deciduous tooth	0
D7140		extraction, erupted tooth or exposed root (elevation and/or forceps removal)	0
D7210		extraction, erupted tooth requiring removal of bone and/or sectioning of tooth, and including elevation of mucoperiosteal flap if indicated	5
D7220		removal of impacted tooth - soft tissue	15
D7230		removal of impacted tooth - partially bony	40
D7240		removal of impacted tooth - completely bony	40
D7241		removal of impacted tooth - completely bony, with unusual surgical complications	90
D7250		removal of residual tooth roots (cutting procedure)	5
D7251		coronectomy – intentional partial tooth removal	40
D7270		tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	50
D7280		exposure of an unerupted tooth	125
D7282		mobilization of erupted or malpositioned tooth to aid eruption	5
D7285		incisional biopsy of oral tissue-hard (bone, tooth)	80
D7286		incisional biopsy of oral tissue-soft	75
D7288		brush biopsy - transepithelial sample collection	30
D7310		alveoloplasty in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0
D7311		alveoloplasty in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0
D7320		alveoloplasty not in conjunction with extractions - four or more teeth or tooth spaces, per quadrant	0
D7321		alveoloplasty not in conjunction with extractions - one to three teeth or tooth spaces, per quadrant	0
D7510		incision and drainage of abscess - intraoral soft tissue	0
D7511		incision and drainage of abscess - intraoral soft tissue - complicated (includes drainage of multiple fascial spaces)	50

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Code	Description	Copayment
D7960	frenulectomy - also known as frenectomy or frenotomy - separate procedure not incidental to another procedure	165
D7963	frenuloplasty	165
D7970	excision of hyperplastic tissue - per arch	200
D7971	excision of pericoronal gingiva	0

Other Services

Code	Description	Copayment
D9110	palliative (emergency) treatment of dental pain - minor procedure	25
D9120	fixed partial denture sectioning	35
D9210	local anesthesia not in conjunction with operative or surgical procedures	0
D9211	regional block anesthesia	0
D9212	trigeminal division block anesthesia	0
D9215	local anesthesia in conjunction with operative or surgical procedures	0
D9310	consultation - diagnostic service provided by dentist or physician other than requesting dentist or physician	20
D9430	office visit for observation (during regularly scheduled hours) - no other services performed	0
D9440	office visit - after regularly scheduled hours	25
D9450	case presentation, detailed and extensive treatment planning	0
D9610	therapeutic parenteral drug, single administration	15
D9612	therapeutic parenteral drugs, two or more administrations, different medications	30
D9630	drugs or medicaments dispensed in the office for home use	25
D9910	application of desensitizing medicament	5
D9911	application of desensitizing resin for cervical and/or root surface, per tooth	5
D9932	cleaning and inspection of removable complete denture, maxillary	25
D9933	cleaning and inspection of removable complete denture, mandibular	25
D9934	cleaning and inspection of removable partial denture, maxillary	25
D9935	cleaning and inspection of removable partial denture, mandibular	25
D9940	occlusal guard, by report	120
D9941	fabrication of athletic mouthguard	60
D9942	repair and/or reline of occlusal guard	60
D9943	occlusal guard adjustment	15
D9951	occlusal adjustment - limited	35
D9952	occlusal adjustment - complete	75
D9970	enamel microabrasion	20
D9971	odontoplasty 1 - 2 teeth; includes removal of enamel projections	5
D9972	external bleaching - per arch - performed in office	200
D9973	external bleaching - per tooth	100
D9974	internal bleaching - per tooth	100
D9975	external bleaching for home application, per arch; includes materials and fabrication of custom trays	200
D9991	dental case management – addressing appointment compliance barriers	0
D9992	dental case management – care coordination	0
D9993	dental case management – motivational interviewing	0
D9994	dental case management – patient education to improve oral health literacy	0

Orthodontics

Code	Description	Copayment
	Removable orthodontic retainer adjustment	0
	Consultation	25
	Failed/no-show appointment without 24-hour notice	25
	Full banded - child, up to age 19	1000
	Full banded - adult	1000
	Partial banded - child, up to age 19	750
	Partial banded - adult	750
	Mixed dentition - phase 1	450
	Palatal expansion	350
	Rapid palatal expansion	550
	Retention appliance - after orthodontic treatment	180
	Functional appliance (Bionator-Frankel)	550
	Headgear	350
	Simple crossbite	275
	Copying records	40

Please call your Dental Health Services Member Service Specialist at 800-637-6453 for a referral to a conveniently located participating orthodontist. Orthodontic models, x-rays, photographs and records are not covered. There may be additional copayments depending on treatment needs.

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Dental Limitations

The following are limitations on covered benefits.

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. Covered specialist referrals must be pre-approved by Dental Health Services.
F. Periodontal surgical procedures are limited to four quadrants every two years.
G. There are additional charges for precious/noble metals (gold).
H. 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.
I. Relines are limited to once per twelve months, per appliance.
J. Single unit inlays and crowns are a benefit as provided above only when the teeth cannot be adequately restored with other restorative materials.
K. 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.

Dental Exclusions

The following are not covered by your dental plan.

A. Services that are not consistent with professionally recognized standards of practice.
B. 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.
C. 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.
D. Treatment for malignancies, neoplasms (tumors) and cysts as well as hereditary, congenital and/or developmental malformations.
E. Dispensing of drugs not normally supplied in a dental office.
F. Hospitalization charges, dental procedures or services rendered while patient is hospitalized.
G. 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.
H. Fixed bridges for patients under the age of sixteen, in the presence of nonsupportive 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.
I. General anesthesia, including intravenous and inhalation sedation.
J. Dental procedures that cannot be performed in the dental office due to the general health and/or physical limitations of the member.
K. Expenses incurred for dental procedures initiated prior to member's eligibility with Dental Health Services, or after termination of eligibility.
L. Services that are reimbursed by a third party (such as the medical portion of an insurance/health plan or any other third party indemnification).
M. Extractions of non-pathologic, asymptomatic teeth, including extractions and/or surgical procedures for orthodontic reasons.
N. Setting of a fracture or dislocation, surgical procedures related to cleft palate, micrognathia or macrognathia, and surgical grafting procedures.
O. Coordination of benefits with another prepaid managed care dental plan.
P. Orthodontic treatment of a case in progress and/or retreatment of orthodontic cases.
Q. Cephalometric x-rays, tracings, photographs and orthodontic study models.
R. Replacement of lost or broken orthodontic appliances.
S. Changes in orthodontic treatment necessitated by an accident of any kind.
T. Malocclusions so severe or mutilated which are not amenable to ideal orthodontic therapy.
U. Services not specifically listed on the Schedule of Covered Services and Copayments.

Orthodontic Limitations

The following are limitations on covered benefits.

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, excluding retention, 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

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lose eligibility under the Plans' 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.

Orthodontic Exclusions

The following are not covered by your dental plan.

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.

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

Maximums: The maximum benefit for pedodontic specialty care is $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 four months.

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.

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.

Dental Health Services
A Great Reason to Smile sm

3833 Atlantic Avenue, Long Beach, CA 90807
800-637-6453 | www.dentalhealthservices.com

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VISION CARE PLAN BENEFIT DESCRIPTION

Multi Union Security Trust Fund

$5 Eye Examination Copayment

Premier Plan

For information prior to enrolling visit Davis Vision's website at: **www.davisvision.com**, select the member option and enter client code **3963** or call **1.877.923.2847** (toll free). Once enrolled, please visit Davis Vision's website: **www.davisvision.com**, or call **1.800.999.5431** with questions.

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 Davis Vision member.
- 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
Out-of-Network. . . . . .Reimbursed up to $35

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 any 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 (less the applicable discount). For more information on lenses, please see "What lenses/coatings are included?".
Out-of-Network. . . . . .Reimbursed up to $30 for frames, up to $35 for single vision lenses, up to $45 for bifocals, up to $55 for trifocals, up to $60 for lenticular (post-cataract) 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, and your evaluation, fitting and follow up care will also be covered.
Davis Vision Contact Lens Collection (includes evaluation, fitting, follow-up):

Disposable. . . . . Four boxes/multi-packs[1]

Planned Replacement . . . . Two boxes/multi-packs[1]
In lieu of the Davis Vision contact lenses, members may use their $150 credit, plus a 15% discount off any overage 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 $75 for elective contact lenses, up to $225 for medically necessary contact lenses with prior approval.

Please note: Contact lenses can be worn by most people. Once the contact lens option is selected and the lenses are fitted, they may not be exchanged for eyeglasses. The Davis Vision collection is available at most participating independent provider locations.

[1] Number of contact lens boxes may vary based on manufacturer's packaging.

SAFETY EYEGLASSES

(MEMBERS ONLY). . . . . Every 12 months

In-Network Copayment. $0

You may choose frames from the specified premier safety collection or use your own frame.

Out-of-Network. . . . . Safety eyewear must be received from an in-network provider. There is no out-of-network reimbursement for safety eyewear.

What lenses/coatings are included?[/2]

- Plastic or glass single vision, bifocal or trifocal lenses, in any prescription range.
- Glass grey #3 prescription lenses.
- Oversize lenses.
- Post-cataract lenses.
- Tinting of 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?[/2]

Yes, you can pay the low, discounted fixed fees indicated and receive these exciting optional items:

	Dress	Safety
• Anti-reflective coating		
Standard	$35	$35
Premium	$48	N/A
Ultra	$60	N/A
• Plastic Photosensitive lenses	$65	$65
• High-Index lenses	$55	$55
• Scratch Protection Plan		
Single Vision	$20	N/A
Multifocal	$40	N/A
• Ultraviolet (UV) coating	$12	Included
• Intermediate-Vision lenses	$30	$30
• Polycarbonate lenses(adults)	$30	Included
• Polarized lenses	$75	$75
• Progressive addition multifocal lenses.[/3]		
Standard types	$50	$50
Premium types	$90	$90

2/These lens options and copays apply to in-network benefits only.

3/ 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 will not be refunded.

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 may be 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 website at **www.davisvision.com** or call **1.800.999.5431**.

May I use the benefit at different times?

All available services must be obtained at one time from either a network or an out-of-network provider. To maximize your benefit value we recommend that all services be obtained from a 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 provider’s 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:

Replacement contacts (after initial benefit) through www.DavisVisionContacts.com mail-order service ensures easy, convenient, purchasing online and quick, direct shipping to your door. Log on to our member Website for details.

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.
- Contact lenses and eyeglasses in the same benefit cycle.
- Services not performed by licensed personnel.

For more information, please visit Davis Vision's website at www.davisvision.com or call Davis Vision at 1.800.999.5431 to:

- Learn more about your benefits
- Locate a Davis Vision provider
- Verify eligibility
- Print an enrollment confirmation
- Request an out-of-network provider reimbursement form
- Contact a Member Service Representative

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 or to obtain a copy of Davis Vision's Privacy Practices Notice, please visit Davis Vision's website at: www.davisvision.com or call 1.800.999.5431.

"All insured products are underwritten by either HM Life Insurance Company or HM Life Insurance Company of New York."

Davis Vision may operate as Davis Vision Insurance Administrators in California

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

This Summary of Benefits [and the accompanying Brochure and Enrollment Form explain/explains] the general purpose of the insurance described, but in no way change or affect the policy as it is actually issued. In the event of any discrepancy between any of these documents and the policy, the terms of the policy apply. Complete coverage information is in the certificate of insurance booklet issued to each insured individual. Please read it carefully and keep it in a safe place with your other important papers.

26.06.100.1 (Revised 04/14/2011)

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 Merrill Edge*, 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.

IMPORTANT NOTICE ABOUT

Your Rights and Protections Against Surprise Medical Bills

February 18, 2022

> When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact Employee Benefits Security Administration (EBSA), the No Surprise Help Desk (NSHD) at 1-800-985-3059 or cms.gov/nosurprises or the California Department of Managed Health Care (DMHC), if your plan is fully insured, to ask whether the charges are allowed by law.

Visit https://www.cms.gov/files/document/model-disclosure-notice-patient-protections-against-surprise-billing-providers-facilities-health.pdf for more information about your rights under Federal law.

Visit https://dmhc.ca.gov/ for more information about your rights under California law.

MULTI UNION SECURITY TRUST FUND

Telephone • (818) 243-0222 • www.pacfed-must.com

Re: New Qualifying Payment Amounts and Updates to the Claims and Appeals Procedures
Effective January 1, 2022
(Summary of Material Modifications)

This Summary of Material Modification (SMM) modifies some of the information contained in the Summary Plan Description (SPD) of the Multi Union Security Trust Fund (Plan). In the event of any discrepancy between this SMM and the SPD, the provisions of this SMM will govern.

This summary is intended to satisfy the requirement for issuance of a SMM under ERISA. You should take the time to read this SMM carefully and keep it with the SPD that was previously provided to you. This SMM must be read in conjunction with the SPD and all previous SMMs issued. If you need another copy of the SPD or these SMMs, contact the Trust Fund Office at (818) 243-0222.

I. UPDATES REGARDING LIMITATIONS AND EXCEPTIONS UNDER THE OPTIONS RIDER

Effective July 1, 2022 the “Limitations and Exclusions” under the “MULTIUNION SECURITY TRUST FUND OPTIONS RIDER” policy that is included with your SPD shall be as follows. Changes have only been made to the items 1 and 3 under this section. The remainder of the “Limitations and Exclusions” section of your Options Rider policy remain the same.

Limitations and Exclusions

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

1. Charges that are not included in the categories of "Covered Expenses" as defined in the chart under the “Options Rider Benefit Summary.”
2. Charges for medical services, specialized footwear or any other services that are not Medically Necessary.
3. Charges for benefits that are provided by providers in your HMO benefit plans (currently Anthem BlueCross).

II. UPDATES REGARDING QUALIFYING PAYMENT AMOUNTS

Effective January 1, 2022, new cost-sharing amounts are applicable for items and services within the scope of the surprise billing and cost-sharing protections for (1) out-of-network emergency services, (2) nonemergency services performed by nonparticipating providers at participating facilities, and (3) air ambulance services furnished by nonparticipating providers of air ambulance services.

The Trust offers medical benefits through the Anthem HMO Plan. For services obtained through Anthem HMO, please contact your provider for further information regarding cost sharing amounts for the categories of services described above.

The Trust also provides additional benefits through the Options Rider, as described on pages 29 – 33 of the SPD. If the expense falls into one of these three categories, then your share of the cost will be the same as if the services were obtained in-network, including co-payments and deductibles. In these circumstances, for services obtained through the Options Rider, the provider payment for the three categories of services described above will be the Qualifying Payment Amount (QPA), which is the applicable median-contracted rate set by the provider network, rather than the "customary and reasonable amount" referenced in the SPD. Please note, however, that emergency room charges are not covered under the Options Rider and must be obtained through Anthem HMO , as applicable.

III. <u>CLAIMS AND APPEALS PROCEDURES</u>

Effective January 1, 2022, the Claims and Appeals Procedures under the Plan are revised as follows:

No Employee, Dependent or other beneficiary shall have any right or claim to benefits under the Trust, except as specified in the Summary Plan Description, including any SMMs, 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, except to the extent they may be subject to external review.

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 Administrative 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 the SPD, including any SMMs, 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 Anthem Blue Cross, Dental Health Services, Davis Vision Plan, and Aetna Life Insurance Company, as applicable. For details about each Provider's claims appeal and review procedures, please refer to that organization's Evidence of Coverage booklet or contact the Provider directly. You may obtain an Evidence of Coverage booklet free of charge from the Trust Administrative Office.

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

Your Claim Regarding Eligibility or under the Options Rider must be approved or denied by the Trust Administrative 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 Administrative Office may take up to an additional 90 days to make a decision on the claim.

If the claim is not complete, you or your authorized representative will be notified of the additional evidence required to establish whether or not a claim should be paid. This notification will be provided to you or your authorized representative as soon as reasonably possible, but not later than five (5) days for a pre-service claim or 24 hours for an urgent care claim. For an urgent care claims, the notice may be provided to you or your representative orally, unless you or your representative request a written notice. If you fail to cooperate with such requests, your claim may be denied.

Your Claims made under the Options Rider:

If you have an urgent care claim under the Options Rider, the Trust Office will notify the claimant of its initial determination within 72 hours of receipt of the claim. An urgent claim is a claim for medical care or treatment, the absence of which would seriously jeopardize the life or health of the claimant to regain maximum function or, in the opinion of a physician with knowledge of the claimant's medical condition, subject the claimant to severe pain that cannot be adequately managed without the care or treatment that is the subject of the claim. A health care professional with knowledge of the claimant's medical condition may act as the claimant's authorized representative in claims involving urgent care. If the Trust Office requires additional information from the claimant, it will notify the claimant of its need for additional information within 24 hours of receipt of your claim. Upon receipt of this notice, the claimant will have at least 48 hours to respond.

If you make a pre-service claim under the Options Rider - The Trust Office will notify the claimant of its initial determination within 15 calendar days of receipt of the claim. A pre-service claim is any claim for a benefit under the plan for which the plan requires approval before medical care is obtained. The Trust Office may have one 15 calendar day extension to respond to a pre-service claim if the plan determines that such an extension is necessary due to matters beyond the control of the plan. If the extension is necessary, the Trust Office will notify the claimant within the normal deadline. If the extension is necessary because the claimant failed to provide necessary information, the notice of extension will specify the information needed. The claimant will have at least 45 days to respond if additional information is requested.

If you make a post-service claim for benefits under the Options Rider - 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.

If you make a concurrent claim under the Options Rider – A concurrent claim is a claim that is reconsidered after an initial approval was made and results in a reduced or terminated benefit. The plan will notify the claimant of such a reconsideration early enough to have an appeal decided before the benefit is reduced or terminated. For approved urgent care treatment, any request by a claimant to

extend that treatment will be acted on by the plan within 24 hours after receipt of the claim, provided that any such claim is made to the plan at least 24 hours prior the expiration of the prescribed period of time or number of treatments.

If the plan makes an adverse benefit determination, the claimant will be provided with the right to a full and fair review of the determination. If any claim you make to the Trust is denied, the Trust Administrative Office will notify you in writing, including the following:

(1) the specific reason or reasons for the adverse benefit determination;
(2) reference to the specific plan provisions on which the determination is based;
(3) a description of any additional information or material necessary for the proper processing of the claim and an explanation of the reason it is needed;
(4) notification of the right to appeal and time periods that the claimant needs to follow in order to appeal the claim, plus a statement that the claimant can file a lawsuit under the Employee Retirement Income Security Act (ERISA) but only after first exhausting the claims and appeals procedures;
(5) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, you will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request;
(6) If a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, you will be provided with a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided to you free of charge upon request; and
(7) In the case of Claims involving urgent care, a description of the expedited review process applicable to such Claims.

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 Administrative Office will be happy to assist you in resolving claims issues, please contact the Trust Administrative Office as soon as an issue arises.

PacFed Benefit
Administrators 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 Administrative Office who will assist you in explaining your benefits, or may intervene on your behalf with the Provider. **However, you must contact the Trust Administrative 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 as described herein.

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 180 days of notice of the claim denial of eligibility. With the exception of urgent care appeals, which may be oral, all other appeals must be in writing. You may submit any written records you wish to be reviewed and you may obtain copies of any related Plan records.

2) 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. 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 Administrative 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.

Upon written request, the claimant may review documents that pertain to his claim and denial, and request a formal hearing before the Board of Trustees, which may be granted at the Board of Trustees'

discretion. If the Board of Trustees grants such a hearing, they shall advise the claimant by first class U.S. mail of the date, time, and place of such hearing. If a hearing is granted, it may be before the Board of Trustees, a committee of the Board of Trustees, or a hearing officer appointed by the Board of Trustees. The claimant will also be advised of the claimant's right to be present, to present witnesses on claimant's behalf and to present such evidence as in the claimant's opinion may best be designed to support the petition. The proceedings of such formal hearing may be steno graphically recorded, at the discretion of the Trustees.

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 determination 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.

If the appeal is related to an urgent claim, the Board of Trustees will notify the claimant of its decision within 72 hours from receipt of the appeal. In the event the plan administrator has requested additional information pursuant to an urgent claim, the plan administrator shall notify the claimant of the plan's benefit determination as soon as possible, but in no case later than 48 hours after the earlier of— (A) The plan's receipt of the specified information, or (B) The end of the period afforded the claimant to provide the specified additional information.

If the appeal relates to a pre-service claim, the Board of Trustees will notify the claimant of its decision within 30 days of receipt of the appeal.

If the appeal relates to a post-service claim, the Board of Trustees shall make a benefit determination no later than the date of the meeting of the committee or board that immediately follows the plan's receipt of a request for review, unless the request for review is filed within 30 days preceding the date of such meeting. In such case, a benefit determination may be made by no later than the date of the second meeting following the plan's receipt of the request for review. If special circumstances (such as the need to hold for a hearing which has been requested by the claimant and granted by the Board of Trustees) require a further extension of time for processing, a benefit determination shall be rendered not later than the third meeting of the committee or board following the plan's receipt of the request for review. If such an extension of time for review is required because of special circumstances, the plan administrator shall provide the claimant with written notice of the extension, describing the special circumstances and the date as of which the benefit determination will be made, prior to the commencement of the extension. The plan administrator shall notify the claimant of the benefit determination as soon as possible, but not later than 5 days after the benefit determination is made

If any appeal you make is denied, you will receive written (or electronic as permitted by law) notice, including the following information:

(1) The specific reason or reasons for the decision;
(2) Specific reference to pertinent plan provisions on which the decision is based and informing the claimant of his right to file suit under ERISA after having first exhausted the Plan's claims and appeals procedure;
(3) A statement that you have the claimant has the right to receive, upon request and free of charge, reasonable access to copies of all documents, records, and other information relevant to the claimant's claim for benefits;
(4) If an internal rule, guideline, protocol or other similar criterion was relied upon in making the adverse determination, the claimant will be provided with a statement that such a rule, guideline, protocol, or other similar criterion was relied upon in making the determination and that a copy will be provided to you free of charge upon request;
(5) If a medical necessity or experimental treatment or similar exclusion or limit was relied upon in making the adverse determination, the claimant will be provided with a statement that an explanation of the scientific or clinical judgment for the determination, applying the terms of the Plan to your medical circumstances, will be provided free of charge upon request; and
(6) The following statement: "You and your plan may have other voluntary alternative dispute resolution options, such as mediation. One way to find out what may be available is to contact your local U.S. Department of Labor Office and your State insurance regulatory agency."

This written decision will be sent to the claimant no later than five (5) days after the Board of Trustees decide the appeal, unless special circumstances require an extension of time for processing the appeal, any additional information is required, or an investigation of the facts is necessary.

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, except for claims which have been submitted for external review. The Trustees' decisions are subject to judicial review only for abuse of discretion.

Limitation to File a Lawsuit

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.

IV. EXTERNAL REVIEW PROCEDURES

You may have the right to appeal certain types of adverse benefit determinations to an independent third party after completing an "internal" appeal, as described in the SPD.

Effective January 1, 2022, external review is also applicable to adverse benefit determinations for items and services within the scope of the surprise billing and cost-sharing protections for (1) out-of-network emergency services, (2) nonemergency services performed by nonparticipating providers at participating facilities, and (3) air ambulance services furnished by nonparticipating providers of air ambulance services.

If you have any questions regarding this notice, please contact the Administrative Office at (818) 243-0222. You may also contact the Employee Benefits Security Administration, U.S. Department of Labor at (866) 444-3272 or www.dol.gov/ebsa/healthreform.

If you have a complaint or are dissatisfied with a denial of coverage for claims under your plan, you may be able to appeal or file a grievance. For questions about your rights, this notice, or assistance, you can contact the Administrative Office at (818) 243-0222.

Multi Union Security Trust Fund

June 23, 2023

IMPORTANT NOTICE ABOUT
Extension of Certain COVID-19 services and tests through Nov. 11, 2023; and
Normal Plan Rules Resume July 11, 2023

COVID-19 Tests (Over the Counter (OTC) and PCR), Vaccines and Therapeutic Treatment

The California Department of Managed Health Care (DHMC) is requiring HMOs to extend certain COVID-19 services and tests through November 11, 2023. Below is a summary of **Anthem Blue Cross'** extension of certain COVID-19 services and tests.

Anthem Blue Cross will continue COVID-19 testing (OTC and PCR), vaccines and boosters, and therapeutic treatment (such as Paxlovid) at $0 cost-share through November 11, 2023, whether in or outside the Anthem Blue Cross network. Typically, OTC tests are performed at home, while PCR tests are handled by a laboratory. After November 11, 2023, you must remain within the Anthem Blue Cross network to receive these tests and services at $0 cost share; and any COVID-19 related out-of-network services (e.g., testing, vaccines, and treatment) are only covered for emergency/urgent care situations, if medically necessary and when legally required. You can visit www.anthem.com/ca to learn more about the extension of COVID-19 services that are being extended. You can also call (844) 849-7938.

You can contact the DMHC Help Center at www.HealthHelp.ca.gov or call **1-888-466-2219**.

You can also visit the Multi-Union Security Trust Fund's website at www.pacfed-must.com and download the links for more information.

Normal Plan Rules Resume July 11, 2023 (and End of Extension of Certain Plan Deadlines)

With the extensions issued under the COVID-19 National Emergency expiring on July 10, 2023, the suspension of the Plan's deadlines for COBRA election and payment, HIPAA special enrollment, filing claims and appeals and requests for external review will also come to an end. During the National Emergency, plans were required to disregard the "Outbreak Period" for up to one year when calculating certain plan deadlines. The Outbreak Period will also end on July 10, 2023. Timing for submitting the following documents will revert back to regular Plan timelines starting on July 11, 2023, as follows:

- COBRA - elect COBRA continuation coverage – 60 days after receipt of COBRA notice
- COBRA – start payment of COBRA premiums – 45 days after timely election of COBRA
- Period to file a claim – 12 months
- Special Request for Enrollment – 30 days.
- Appeal from Adverse Benefit Determination – 180 days

Please note that you may not get the full one-year Outbreak Period extension if your original deadline to submit documents is within a year before July 10, 2023. If you believe this may apply to you or if you

have any questions, please call the Administrative Office. You may also review the normal Plan rules in your Summary Plan Description at www.pacfed-must.com

The following are examples of how the extended deadlines apply under new federal guidance:

Example 1 (Electing COBRA)

Facts: Individual A works for Employer X and participates in the Fund. Individual A experiences a qualifying event for COBRA purposes and loses coverage on April 1, 2023. Individual A is eligible to elect COBRA coverage under the Trust and is provided a COBRA election notice on May 1, 2023.

What is the deadline for Individual A to elect COBRA?

Conclusion: The last day of Individual A's COBRA election period is 60 days after July 10, 2023 (the end of the Outbreak Period), which is September 8, 2023.

Example 2 (Electing COBRA)

Facts: Same facts as Example 1, except the qualifying event and loss of coverage occur on May 12, 2023, and Individual A is eligible to elect COBRA coverage under the Fund and is provided a COBRA election notice on May 15, 2023.

What is the deadline for Individual A to elect COBRA?

Conclusion: Because the qualifying event occurred on May 12, 2023, after the end of the COVID-19 National Emergency, but during the Outbreak Period, the extensions under the emergency relief notices still apply. The last day of Individual A's COBRA election period is 60 days after July 10, 2023 (the end of the Outbreak Period), which is September 8, 2023.

If you have questions regarding the end of the COVID-19 Emergency periods, please call the Administrative Office at (818) 243-0222 or (800) 753-0222.